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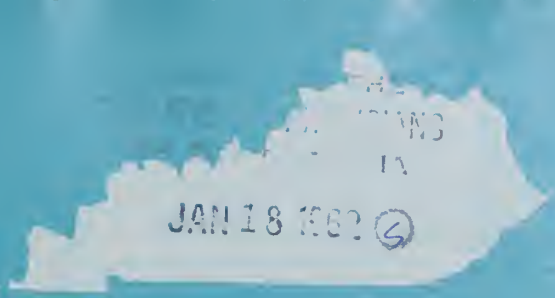
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KSMA INTERIM MEETING OWENSBORO FEB. 22, 1962

The JOURNAL of the Kentucky State Medical Association

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KENTUCKY STATE MEDICAL ASSOCIATION
ORGANIZED 1851

JANUARY 1962 · VOLUME 60 · NUMBER 1

when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent...often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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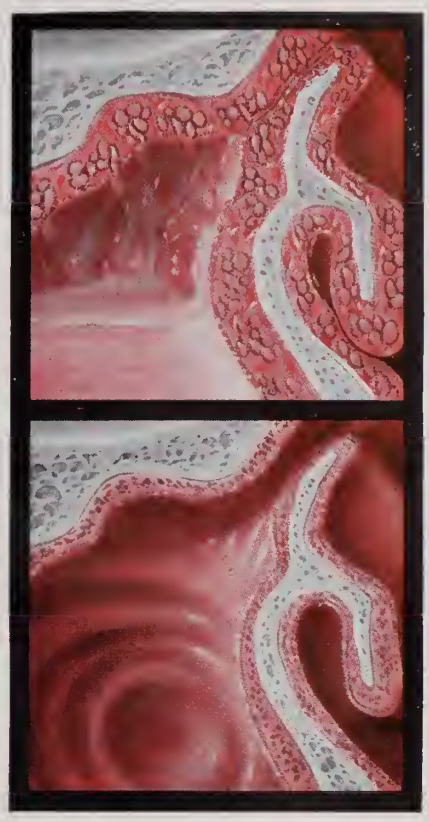
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In colds and sinusitis

unsurpassed in providing drainage space without chemical harm



The clogged sinus
In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

The normal sinus
Magnified anatomy of a portion of maxillary sinus showing mucous membrane with cilia and lymph glands. Ostium is normal and patent.

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NASAL SPRAYS AND SOLUTIONS

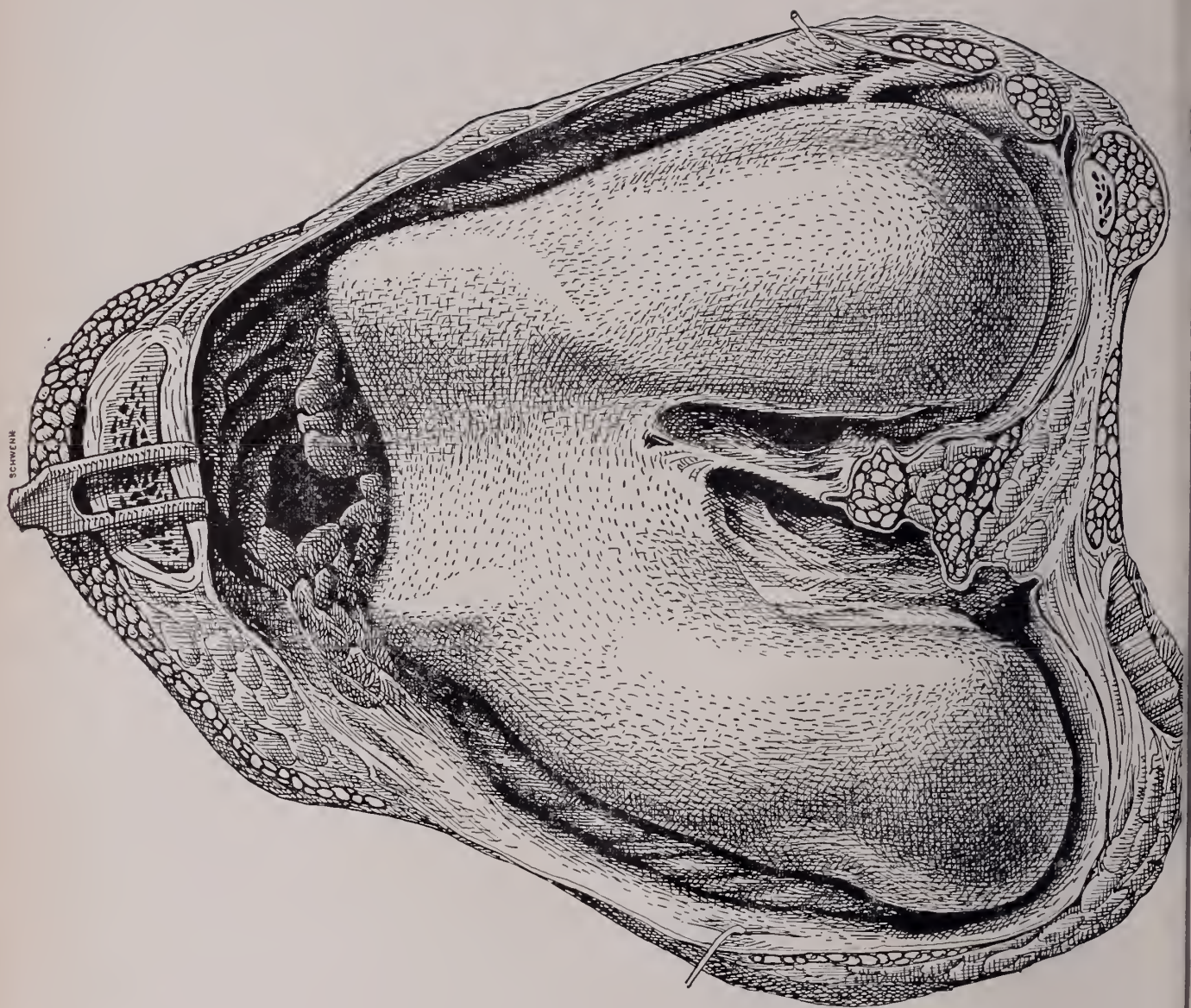
When there is nasal turgescence, tiny orifices of sinus ostia tend to clog. Neo-Synephrine nasal solutions and sprays reduce edematous tissues on contact to provide prompt relief. As turbinates shrink, obstructed sinus ostia open, drainage and breathing become freer and the boggy feeling of a cold disappears.

Delicate respiratory tissue and its natural defenses are not harmed by exceptionally bland Neo-Synephrine; systemic effects are nil; it does not sting. For years it has been recommended for prevention and treatment of sinusitis.[1-3] Repeated applications do not lessen effectiveness.

Available in plastic nasal sprays for adults (½%) and children (¼%), in dropper bottles of ⅛, ¼ or 1 per cent.

1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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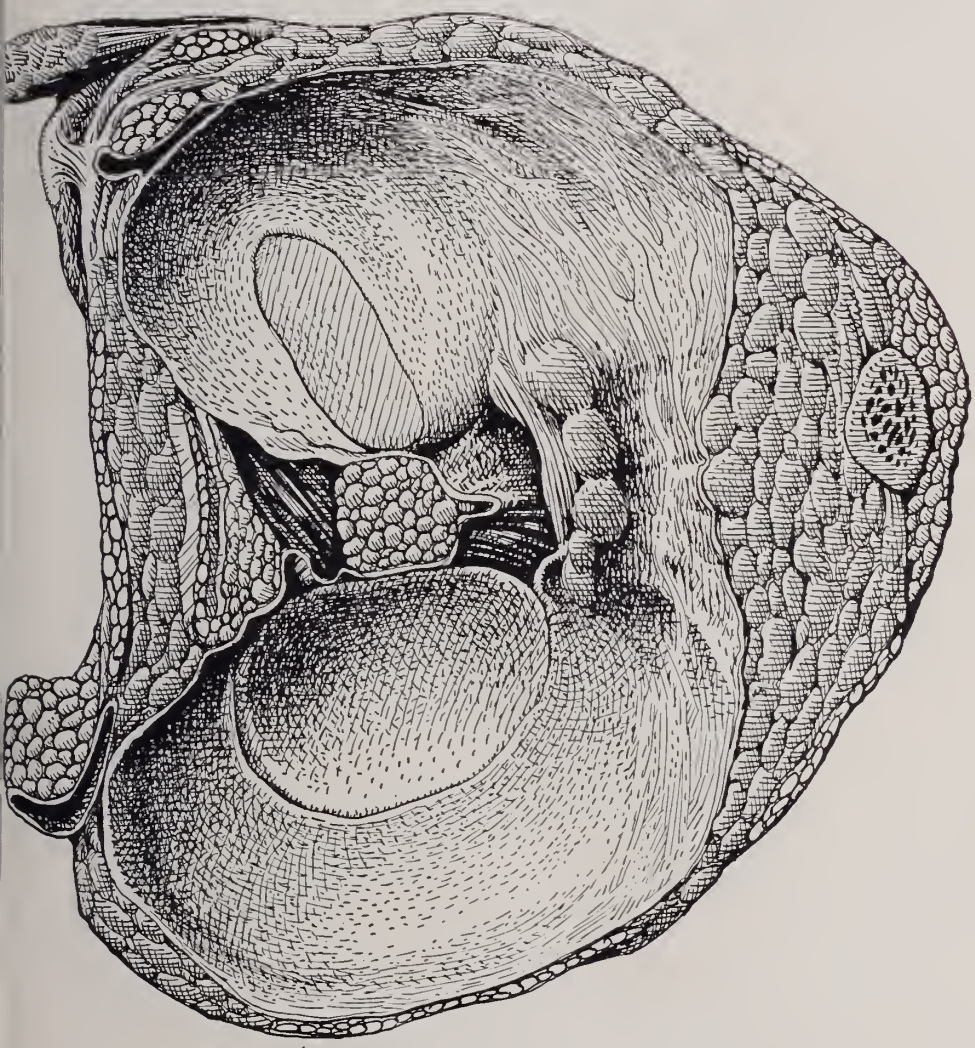
because patients are more than arthritic joints... controlling inflammatory symptoms is frequently not enough!

Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheumatoid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whole patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for the symptom may also be bad for the patient.

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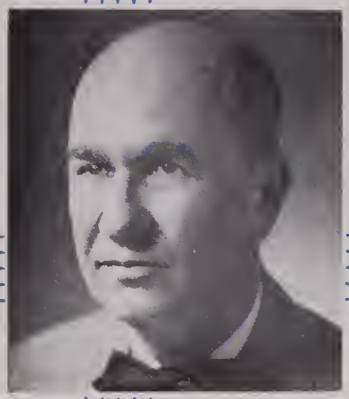
(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

ARISTOCORT is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

Supplied: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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MESSAGE FROM THE PRESIDENT

Must We Bear To The Yoke

THE Social Security Act is a measure established by the Congress of the United States, through its authority to levy and collect a tax, and spend the revenue therefrom in aid of the general welfare. This is a gross tax on wages at a given base, at a given time, and the Supreme Court has ruled on more than one occasion that the Social Security mechanism is not an insurance plan. In financing structure there is approximately a 20% reserve and the remainder is handled on a "pay as you" go basis.

The philosophy and general concept of this tax was to provide a basic foundation of protection against want and destitution. It has been amended and liberalized in 1939-50-52-54-56-58 and 60. Originally the tax rate was 1% for each the employee and the employer on the first $3,000 of wages. This rate has gradually increased now to 3% for each of these contributors and a 4½% on the self employed since 1954, and the wage base has increased to $4,800 per annum. Without further amendments the rate will be 4½% for each of the employee and employer and 6.75% for the self employed in 1969. The base has now broadened to include wives of retired workers, widows and dependent mothers of deceased insured workers, and children, age 18 or over who are totally disabled if their parents are retired or deceased workers.

The Social Security taxes in Europe might be of interest. In four basic categories, namely, Old Age Survivors Disability, Maternity, Family Allowance and Work Injuries—the French employer pays 27.25% of payroll and his employee 6%. In West Germany the respective figures are 13.65% and 11%, and in Italy the employer's contribution is a minimum of 34.6 and a maximum of 72% varying with the industry for the employer and a 5.25% for the employee.

These questions should come to our minds:

(1) Do we want our government to continue to expand the Social Security programs until in America we have such burdensome tax loads, along with the many local, county, state and federal taxes which we already have?

(2) By what formula should our Social Security supported program expand?

(3) Will this "cradle to the grave security pogram" tend to stultify the initiative of private citizens to provide resources for his declining years, as has been our custom in this country?

(4) Is this philosophy not foreign to that upon which our greatness as a nation has accrued?

(5) Should a practical Social Security program be based upon any criteria except demonstrated need of an individual citizen?

D. S. Simpson

AN IMPORTANT ANNOUNCEMENT

to

MEMBERS

of the

KENTUCKY STATE MEDICAL ASSOCIATION

You Will Receive Soon Details of

THE MOST ADVANTAGEOUS

Income Replacement Program

When Disabled

A. P. LEE, Administrator

315 Guthrie Street JUniper 3-1888

Louisville, Kentucky



Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Thorazine® brand of chlorpromazine
a fundamental drug in both
office and hospital practice
Smith Kline & French Laboratories SK&F

posed by professional models

'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference,* and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE

Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Alcoholism—Severely agitated patients: *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

For Behavior Disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Jaundice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'★ are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

SUPPLIED

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

★'Levophed' and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levarterenol and phenylephrine respectively.



THE INSURANCE PAGE



Health Cost Control—An Industry View

INDUSTRY today, from the viewpoint of both labor and management, is deeply concerned with the rising costs of health care.

The following excerpts, taken from a recent address by R. Conrad Cooper, executive vice president, personnel services, United States Steel Corporation, express the views of at least one representative of management, regarding the role which physicians should assume in this problem.

"Medical care in this country is a very complex fabric which has produced the highest quality of such service in the world. This has been brought about by those in the medical profession performing in consonance with the free enterprise system.

"All of us, of course, favor continued improvement in the quality of service. And I believe it is clear that costs must be controlled or reduced.

"As you know, many people other than industrial management are also concerned about the continuing rise in the costs of medical care.

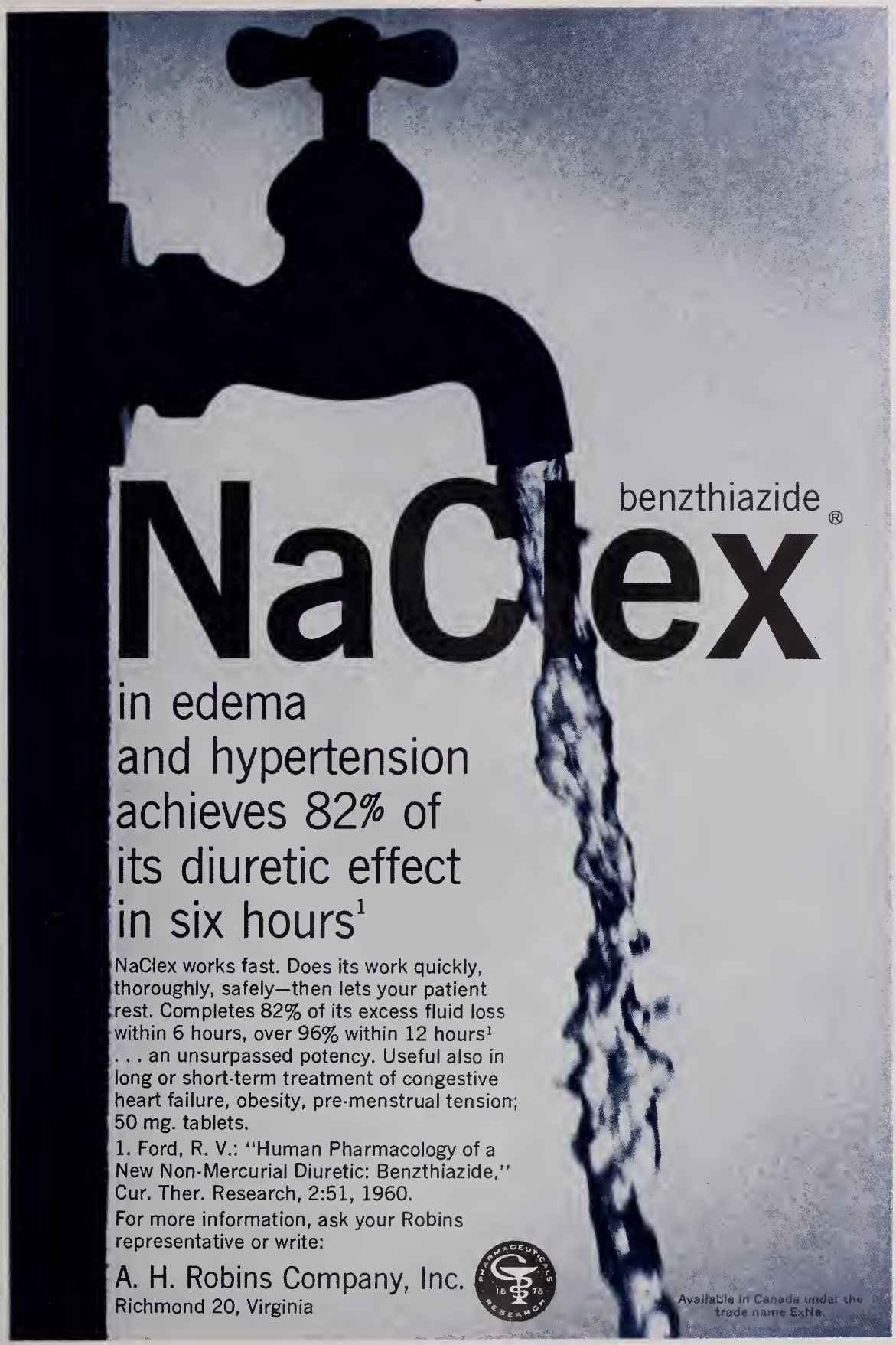
"The major element contributing to the rise in costs has been in hospital expense. Part of this rise has been due to increased employment costs for hospitals; part is due to advance in medical knowledge which required newer diagnostic and treatment facilities. But part is also due to the rate of utilization of hospital facilities and services and of medical and surgical procedures.

"And unfortunately, there appear to be some physicians who do not recognize their role in this. Costs due to medical advancement are all to the good; and costs due to rising capital and operating expenses may be beyond the physician's control. But it is the physician who makes the decision as to who is hospitalized, when and for how long, what hospital services will be used, when the patient is discharged, whether surgery will be performed, whether and for how long a man stays out on sickness disability benefits, etc. All of these are determinants in the total expenditures for illness.

". . It has been said that the rise in costs will continue until the only one able to pay for it will be Uncle Sam, and then we will have socialized medicine. If costs continue to rise without end, this could happen. We in industry do not want socialized medicine, any more than we want socialized industry.

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(From an address given before the Scientific Academy of the American Academy of General Practice in Miami Beach, April 17, 1961.)


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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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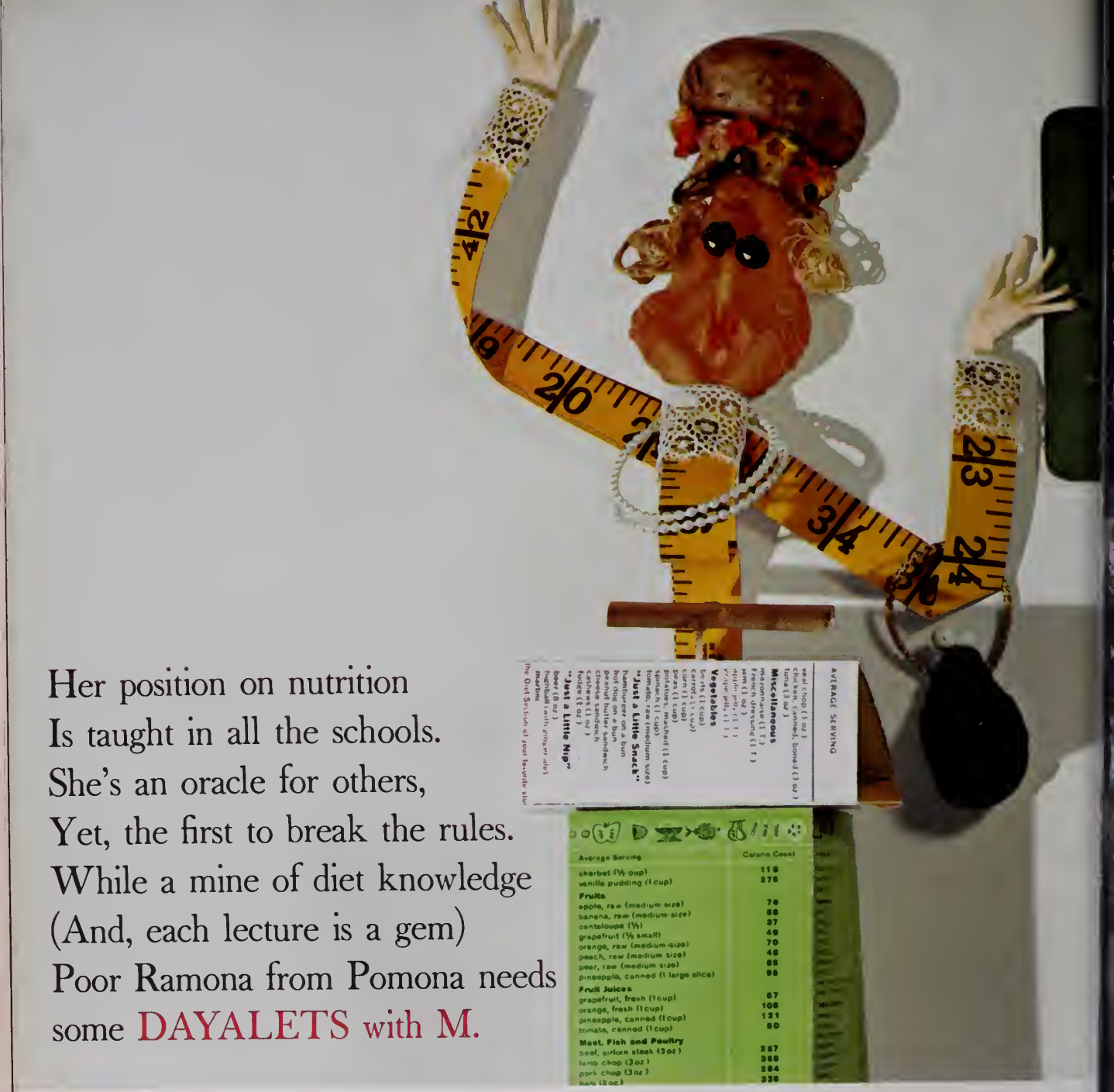
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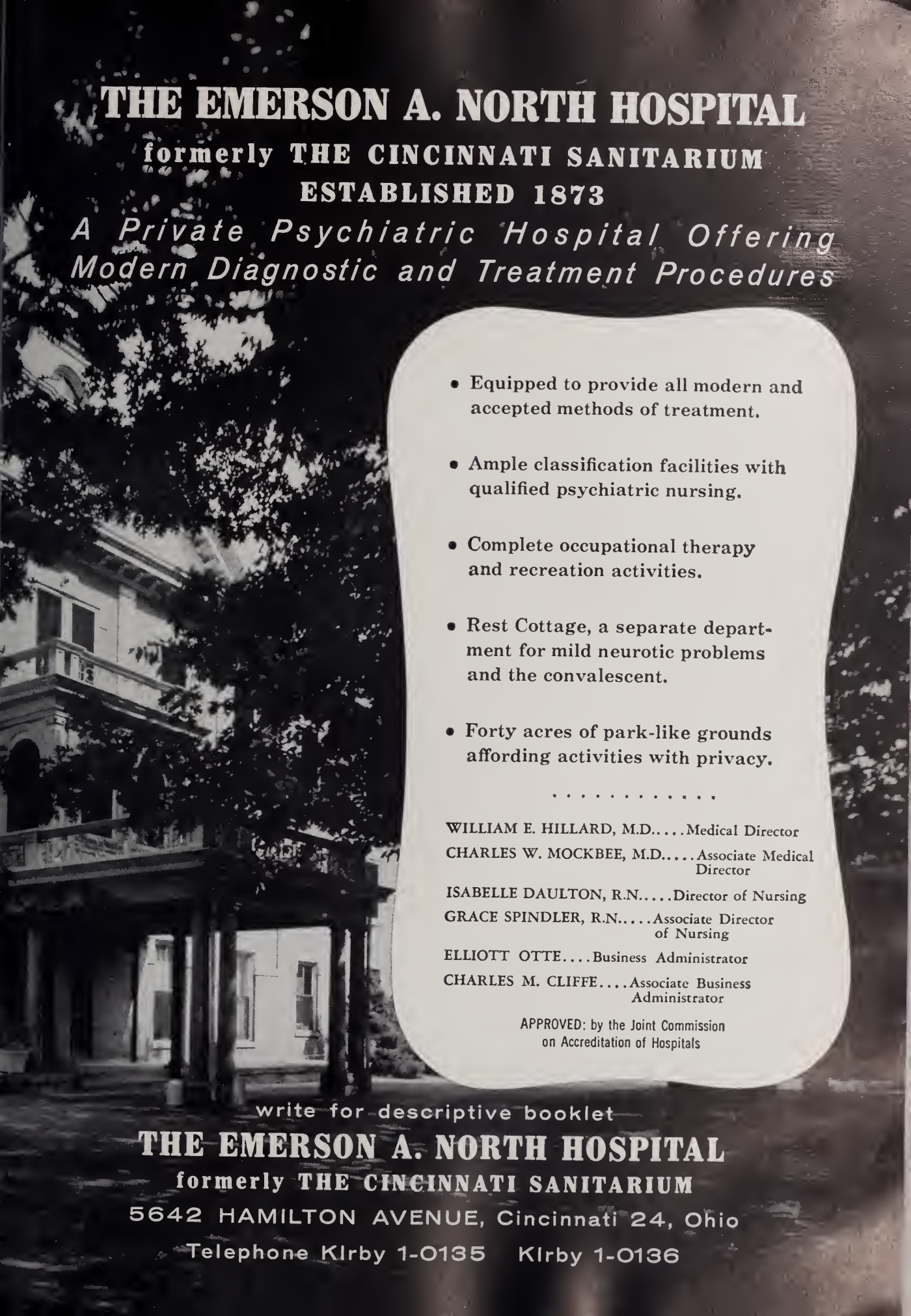


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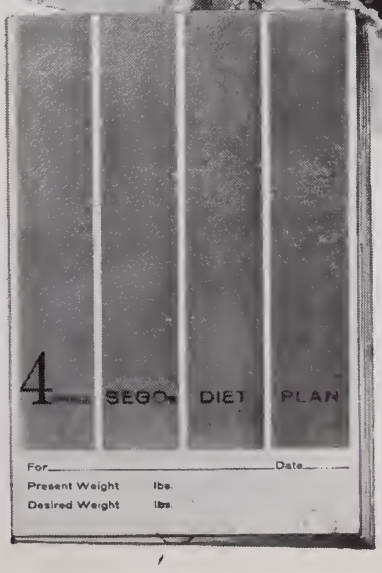
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WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—The Kennedy Administration and other main supporters of medical care of the aged under social security are preparing to make an all-out effort to push the legislation through Congress in the 1962 session.

Their campaign poses a serious challenge to the medical profession and its allies in the fight against such compulsory government health schemes.

It is too early to evaluate the effect on the legislation of changes in House Democratic leadership and House Ways and Means Committee membership. The White House has been exerting pressure in an effort to have a congressman supporting its views named as a replacement for Rep. Frank Ikard (D., Tex.), who resigned. Ikard opposed proposals to put health care under social security.

Administration officials from President Kennedy down publicly gave the Administration medical care legislation, the King-Anderson bill, top priority for the 1962 session. During the interim after the adjournment of the 1961 session, the Administration held a political roadshow in key cities in an effort to build up public support for the King-Anderson bill and other Administration proposals that did not fare so well in Congress. At a number of the so-called White House Regional Conferences, physicians forcefully expressed the medical profession's opposition to putting health care under social security.

The AFL-CIO geared for a renewed fight for the Administration legislation. A new national organization of the elderly has been formed with the main purpose of lobbying for the King-Anderson bill. It is the National Council of Senior Citizens for Health Care Through Social Security. Former Rep. Aime J. Forand (D., R.I.), who sponsored such legislation when he was in Congress, was the leading figure in organizing the group and is national chairman.

On the other side of the fight, there also is a new organization—The American Medical Political Action Committee. It is a non-profit, voluntary, nonpartisan, unincorporated committee set up last May with the approval of the AMA Board of Trustees. AMPAC—which functions independently of medical organizations and societies whether at the national, state or local level—was organized to meet "an unmet need—the need of providing the medical profession with an opportunity to assume a more active and effective role in public affairs," The AMA Board of Trustees and House of Delegates at Denver, in November urged that all physicians, their wives and interested friends join AMPAC and similar political action committees in their states and communities.

Leonard W. Larson, M.D., AMA president, warned the House of Delegates that physicians "are engaged in a historic struggle to preserve our country's unique system of medical care and our stature as a profession." He said both are "seriously threatened" by such legislative proposals as the King-Anderson bill.

Doctor Larson said that the AMA could expect "even more bitter attacks" than those so far from Administration and AFL-CIO spokesmen. He appealed to physicians to support medicine's friends in Congress with money and personal campaign assistance. He noted that AMPAC provides "a national mechanism through which physicians and their families can channel funds for strategic placement where the money will do the most good."

A leading congressional opponent of health care under social security also warned of the seriousness of the fight ahead. Sen. Wallace F. Bennett (R., Utah), a member of the Senate Finance Committee which handles such legislation, told students at Harvard University Medical School that there undoubtedly would be "a determined drive to rush H.R. 4222 (the King-Anderson bill) through the Congress" in 1962.

"The propagandists who are behind the determined drive for a system of socialized medicine have latched on to an emotional appeal in trying to push this legislation through the Congress," Bennett said. "They have tried to create a public image that the AMA and any individual who opposes this plan is motivated by selfish interests.

"As one who is vigorously opposed to compulsory Federal medical care, I resent the tactics used by those who advocate this system of socialized medicine. There is an answer to this problem of meeting the medical needs of our aged, and I frankly believe that it is being honestly met by our present voluntary health insurance programs and by the cooperative federal-state aid to our needy aged who are incapable of paying their own medical expenses.

"I am opposed to H.R. 4222 or other bills which would open the flood gates to a system of compulsory medical care, directed first to our aged, but which, once instituted, would surely by political pressure be expanded to all of our population. The battle over this legislation in this next Congress is bound to be hectic and monumental. It is a battle we can't afford to loose."

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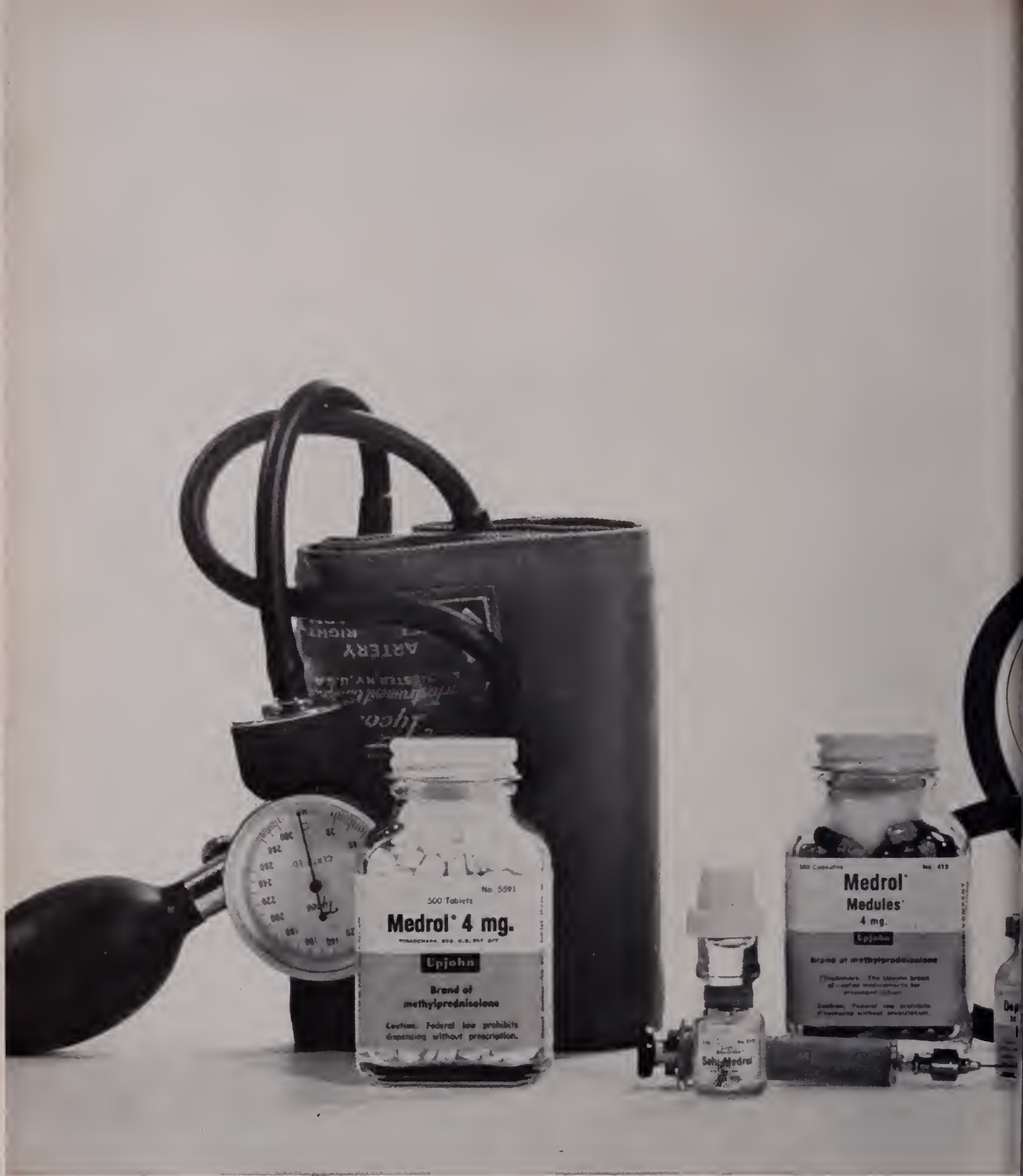
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VOL. 60 JANUARY, 1962 NO. 1

An Evaluation Of Thyroid Function Tests*

JOHN B. SELBY, M.D.

Lexington, Kentucky

The commonly used thyroid function tests were evaluated in 318 patients. Radioactive upstate studies proved superior in some diseases while the PBI was better in others.

AN evaluation of present-day thyroid function tests is not new, but comparison of data from different medical centers is sometimes difficult. This is a review of data at the Lexington Clinic, that has helped us to evaluate the local problem. Regardless of the theoretical advantages of one test over another, the practical fact of technical error often outweighs all other considerations. It is because of technical problems, for example, that we have been forced temporarily to abandon the red-cell uptake of I^{131}-labeled T^3, despite the many other advantages of this test. The present study is concerned chiefly with the standard tests of thyroid function: the basal metabolic rate (BMR), the protein-bound iodine (PBI), and several modifications of the I^{131} uptake.

Plan of Study

In this study, the records of 341 patients, covering a period from 1957 to 1960, were reviewed. Although all of these patients had had thyroid function tests, evaluation of these tests often was difficult and many cases had to be excluded from the study. In general, the following reasons were used for excluding a case from this study:

1. Definitive diagnosis not established.
2. Previous use of iodized radiopaque dyes (within two months for IVP; within six months for gallbladder x-ray).
3. Recent antithyroid drugs or estrogens.
4. Recent use of inorganic iodide.
5. Recent use of desiccated thyroid (except TSH test).
6. Recent radioiodine treatment (within two months).
7. Recent thyroidectomy (within two months).
8. Nephrosis or liver disease.

To evaluate a thyroid function test, criteria other than the test itself were used. The diagnosis was based on the history, physical examination, laboratory data in general, response to treatment, and an adequate follow-up. From these data, the cases were divided into the following six groups:

1. Euthyroid patients without thyroid disease.
2. Euthyroid patients with a goiter.

*Read at Annual Meeting of Kentucky State Medical Association, Kentucky Chapter of American College of Physicians, September 22, 1960.

3. Exophthalmic goiter (Graves' disease).
4. "Toxic" nodular goiter.
5. Hypothyroidism.
6. Miscellaneous conditions: Pituitary disease, subacute thyroiditis, Hashimoto's thyroiditis, colloid goiter (proven), carcinoma of thyroid.

A sufficient number of cases were studied to allow evaluation of the three principal types of thyroid function tests, i.e., radioiodine tracer studies, PBI, and BMR. We have used radioiodine chiefly as a 24-hour uptake study. Although this test is the standard one, in special situations we also have used the 6-hour I^{131} uptake study, the T^3 (tri-iodothyronine) suppression of I^{131} uptake, the TSH stimulation of I^{131} uptake, and the graphic I^{131} uptake study (scintigram). In suspected Graves' disease (exophthalmic goiter) with a borderline high uptake of between 40 and 55 per cent in 24 hours, we have used a standard T^3 suppression test:

T^3 Suppression Test

1. Standard 24-hour radioiodine uptake study.
2. Tri-iodothyronine, 100 mcg. daily, for three to four days.
3. After a background count and with a somewhat larger tracer dose, repeat number 1 on the last day of tri-iodothyronine therapy.

The repeat uptake study should not fall more than 10 per cent if the patient has Graves' disease. In some patients who already are receiving desiccated thyroid, an I^{131} uptake study gives a deceptively low value. In this situation, 5 or 10 units of thyroid-stimulating hormone (TSH) are given intramuscularly for one to four days and then the uptake study is repeated. A normal thyroid will usually respond with a pronounced increase in the uptake of I^{131}. This test also distinguishes primary thyroid deficiency (such as primary thyroidal atrophy or Hashimoto's goiter) from secondary thyroid deficiency due to pituitary disease. TSH will not cause a significant rise in the uptake in thyroidal myxedema or Hashimoto's disease, but should do so in pituitary insufficiency. We have used the radioiodine scintigram chiefly to evaluate solitary and toxic nodules and to search for metastatic carcinoma of the thyroid after total thyroidectomy.

Results in Euthyroid Patients

The records of 318 patients were found suitable for analysis (table 1). Of this number,

Table 1
Summary of Study

Diagnosis	Number of Cases
Euthyroid controls	161
Euthyroid with goiter	43
Toxic diffuse goiter	40
Toxic nodular goiter	13
Hypothyroidism	35
Miscellaneous (thyroiditis, carcinoma, etc.)	26
Total	318

161 could be classified as controls, i.e., as euthyroid persons without thyroid disease. It was hoped that with our more refined tests we could expect at least 95 per cent of these euthyroid patients to fall within our normal ranges. This hope was realized with both the 6-hour and the 24-hour radioiodine uptake studies (table 2). However, it was not realized

Table 2

Euthyroid Controls

Test	Number of cases	Per cent within normal range
24-hour I^{131} uptake	54	95% (11.9 to 46%)
6-hour I^{131} uptake	11	100% (7.5 to 25%)
PBI	129	88% (3.5 to 8 mcg.)
BMR	14	79% (+13 to −13%)

with the PBI test, in which 12 per cent of our euthyroid patients had values outside the range of 3.5 to 8.0 mcg. per 100 ml. of serum. Although every effort was made to exclude patients using estrogens or iodides, I have no doubt that this remains a stumbling block in evaluating this test. Too often, the history is faulty in this regard, and occasionally there is a patient who shows persistent elevation of the PBI for more than six months following an x-ray of the gallbladder. Therefore, despite every effort to improve the technical accuracy of the PBI test in the laboratory, it has real

shortcomings. From a practical standpoint, at least, the radioiodine uptake seems to be less affected by these extraneous sources and would be a better routine test of thyroid function when doubt exists as to the possible previous use of iodides or estrogens. The reliability of the standard basal metabolic rate (BMR) as a thyroid function test has always been questioned, because of the large number of diseases that affect the metabolic state and because of the difficulty in achieving the basal state. A BMR was performed on only 14 of our 161 control patients as a diagnostic test. In this small group of selected normal subjects, it was abnormal in 21 per cent. The serum cholesterol in a similar number of these euthyroid patients was highly variable, ranging from 210 to 404 mg. per cent. Although rarely used in this group of patients, the administration of TSH always produced a marked increase in radioiodine uptake and the administration of T^3 always produced a marked decrease in radioiodine uptake.

The second group of patients was comprised of 43 euthyroid patients who had goiters. These were nodular or diffuse goiters that could not be clearly classified and from which no tissue was available for study. Here, again, radioiodine uptake values were more often normal than the PBI, although the reliability was less than 90 per cent for both. Unfortunately, there were not enough BMR's in this group for a valid comparison, although the 6 patients studied were all within the normal range. The value of multiple tests is well illustrated in this group. Both of the 2 patients who had an abnormal radioiodine uptake had normal PBI values. And, again, although rarely used, the TSH test always showed a dramatic increase in the radioiodine uptake, as expected.

Results in Graves' Disease

The third largest group of patients studied were the 40 who had toxic diffuse goiters (Graves' disease). Although the ages of these patients varied from 16 to 74, the median age was 44. All of these patients had a firm, diffuse thyroid enlargement with or without nodules, or practically no goiter at all. The majority had some of the eye signs of Graves' disease. The radioiodine uptake study was of the greatest diagnostic value in these patients (table 3).

Only 3 of the 37 tested were within the normal range of the 24-hour uptake, i.e., 11.9 to 46.0 per cent. All 3 of these would have been suspicious, since their values were over 42.0 per cent. The 6-hour uptake, when used, was equally reliable. In 2 patients the T^3 test was employed, and after three or four days of 100 mcg. of T^3, both patients showed less than 5 per cent reduction in their uptake. Occasionally a euthyroid patient will present the picture of so-called "malignant exophthalmos" or the hyperophthalmopathy of Graves' disease. These patients have the abnormal thyroid gland of Graves' disease but may be seen in a remission of their hyperthyroidism and thus are not truly "toxic." Nevertheless, they will show an abnormal response to the T^3 test. One of our second group of patients presented this picture and had a normal BMR, a normal PBI, and a 24-hour I^{131} uptake of 22 per cent. Following four days of tri-iodothyronine (Cytomel®), 100 mcg. per day, a repeat 24-hour I^{131} uptake was 23 per cent.

Table 3

24-hour Radioiodine Uptake Values in Various Thyroid States

Diagnosis	Number of cases	Within normal range*
Euthyroid controls	54	95%
Euthyroid with goiter	17	88%
Toxic diffuse goiter	37	8%
Toxic nodular goiter	10	80%
Hypothyroidism	13	38%

*11.9 to 46.0% uptake in 24 hours

Our experience would indicate that the 6-hour or 24-hour radioiodine uptake, supplemented when necessary by the T^3 suppression test, gives a diagnostic accuracy in Graves' disease that seldom can be equalled in medicine. The BMR's in the 11 patients tested were all elevated and gave a better correlation with the *degree* of hyperthyroidism than any of the other tests. The cholesterol values were all within the normal range.

Toxic Nodular Goiter

Only 13 of our patients were classified in the group of toxic nodular goiter. These patients all had a history of a large, long-standing goiter that progressively enlarged and finally became

"toxic." None showed eye signs. Their ages were all over 47, with a median age of 68. When scintigrams were used and demonstrated a "hot" or overactive nodule, these nodules were always of large size (usually larger than the one shown in figure 1). More often, the scintigram demonstrated a more diffuse and patchy hyperfunction in a huge gland, rather than one single "toxic" nodule. The standard 6-hour and 24-hour I^{131} uptake tests were of no help whatever in determining the presence of hyperthyroidism in this group. In fact, the majority of patients classified as toxic nodular goiters showed normal 6-hour or 24-hour uptake values. The PBI showed its greatest usefulness in this difficult group (table 4). All

Table 4

PBI Values in Various Thyroid States

Diagnosis	Number of cases	Within normal range*
Euthyroid controls	127	90%
Euthyroid with goiter	35	80%
Toxic diffuse goiter	18	11%
Toxic nodular goiter	8	0%
Hypothyroidism	30	13%

*3.5 to 8.0 mcg. per 100 ml. serum

patients clinically judged as thyrotoxic had abnormally high PBI values. The BMR was rarely done; but when it was done, it confirmed the clinical impression.

Hypothyroidism

There were 35 patients with hypothyroidism in this study. Six of these patients had definite goiters and presumably had Hashimoto's thyroiditis. The rest of them were equally divided into patients with "spontaneous" myxedema and those with myxedema induced by I^{131} therapy or surgery. Here, again, the standard 24-hour radioiodine uptake study was a poor second to the PBI. We have found radioiodine uptake of practically no assistance in evaluating the patient at a two-month period after I^{131} treatment. Perhaps this is due to the temporary radiation thyroiditis induced; but in any event, a longer time than two months must elapse after therapy before this test can be utilized again. Let me emphasize that the standard 6-hour uptake is preferred to the 24-hour uptake to detect suspected hypothyroidism, but we used it on only 4 patients. In all of these, the 6-hour uptake was less than 7.3 per cent (normal, 7.0 to 25.0 per cent). The TSH test, when used, also proved reliable, in that none of the 3 patients with primary myxedema showed a significant rise in I^{131} uptake.

The PBI proved reliable 87 per cent of the time in hypothyroidism, which is a far better score than shown by the 24-hour I^{131} uptake or the BMR studies. Although the PBI represents thyroxine in most instances, some iodinated noncalorigenic substance may be measured as PBI in patients with goiters, especially Hashimoto's goiter.[1] In the group of hypothyroid patients with goiters, a BEI (butanol-extractable iodine) probably would have been the better test, since it may exclude this noncalorigenic material. In only 3 patients with a goiter was a BEI performed (Bio-Science Laboratories), and it did prove helpful in confirming the diagnosis of hypothyroidism. The BMR was within the normal range in 25 per cent of these patients with myxedema (table 5).

Table 5

BMR in Various Thyroid States

Diagnosis	Number of cases	Within normal range*
Euthyroid controls	14	79%
Euthyroid with goiter	6	100%
Toxic diffuse goiter	11	0%
Toxic nodular goiter	2	..
Hypothyroidism	12	25%

*The data of Boothby and Sandiford are used, in which the range that includes 95% of euthyroid persons is from +13% to −13%.

The least helpful test, the serum cholesterol, was not above our normal range in 9 of the 15 serums tested.

Results in Miscellaneous Cases

The miscellaneous group of 26 patients includes 7 cases of Hashimoto's disease without clinical hypothyroidism, 6 colloid goiters, 7 cases of subacute thyroiditis, 3 cases of papillary carcinoma, 2 cases of pituitary insufficiency, and 1 case of acromegaly.

Table 6 illustrates the typical findings of thyroid function studies in patients with the two common forms of so-called "thyroiditis." Undoubtedly the best test for the acutely tender

Table 6

Thyroid Function Tests in Thyroiditis

Diagnosis	Number of cases	PBI (mean)	24-hr. radio-iodine uptake (mean)	BMR (mean)
Subacute thyroiditis	7	6.7	2.7%	..
Hashimoto's disease*	9	4.7**	32.0%	—12

*Two proved by biopsy.
**BEI low in three patients.

gland of subacute throiditis is the I^{131} uptake, which was markedly reduced in every patient tested. The PBI was usually normal or only slightly elevated, and the sedimentation rate was over 80 mm. per hour by the Westergren method in every patient. In the nontender goiter of Hashimoto's disease, the standard I^{131} uptake tends to be normal or elevated and has a very limited value. However, an elevated I^{131} uptake in the presence of a low BMR and a normal to low PBI (or, better, a low BEI) would be strong confirmatory evidence. As can be seen from table 6, the average PBI was normal in both types of thyroiditis, but the BMR was definitely on the "low side" in Hashimoto's disease. In the group of colloid goiters all the PBI values were normal. Thyroid function in the patient with acromegaly was normal. The patients with pituitary insufficiency did demonstrate over a 50 per cent rise in their I^{131} uptakes after two and four days of TSH, respectively. The usual thyroid function studies were of no value in the patients with papillary carcinoma, but scintigrams were occasionally of value postoperatively to detect residual carcinoma. It has been shown that the uptake of I^{131} by thyroid carcinoma correlates well with the histologic appearance of the carcinoma,[2] i.e., that a colloid-forming carcinoma will pick up I^{131}. We were fortunate in having one of that type in this group. However, it is important to remember that normal thyroid tissue will pick up I^{131} much more avidly than carcinomatous thyroid tissue.

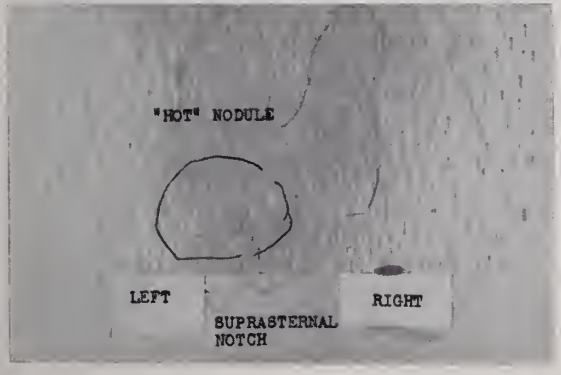


Fig. 1: Scintigram—"hot" nodule.

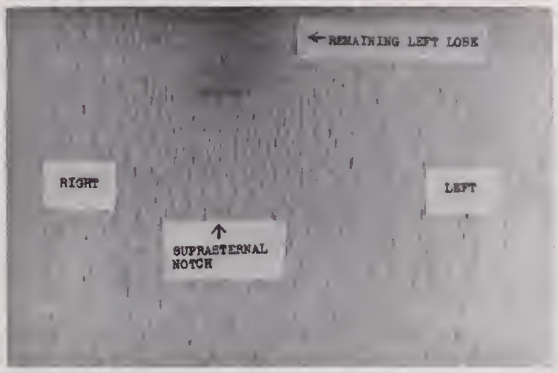


Fig. 2(a): Scintigram with residual left lobe.

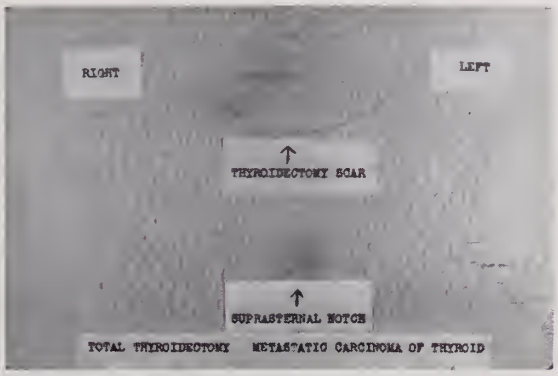


Fig. 2(b): Scintigram of same patient after total thyroidectomy, showing metastatic carcinoma.

Figures 2(a) and 2(b) demonstrate this in a patient in this series. When the normal residual left lobe of the thyroid remained, metastatic carcinoma in the neck could not be demonstrated. After removing the source of competition, the thyroid carinoma picked up the I^{131} beautifully and could be effectively treated.

Comments and Summary

The records of 318 patients were analyzed to assay the practical value of the commonly used thyroid function tests. When the clinician suspects thyrotoxicosis in a patient with a small or diffuse goiter, our experience would indicate that the 6-hour or 24-hour radioiodine uptake study is clearly the best diagnostic tool available. In subacute thyroiditis, the radioiodine uptake by the thyroid is reduced to virtually nothing, and here again the radioiodine uptake tests have remarkable diagnostic accuracy. Con-

sidering that one textbook[3] lists 74 different tests of thyroid function using radioiodine, it is obvious that no diagnostic clinic can be prepared to carry out more than a few of these tests. There are several simple modifications of the standard I^{131} uptake that have helped us. The thyroid stimulating hormone (TSH) test has helped in distinguishing primary from secondary (pituitary) thyroid deficiency and in the diagnosis of patients whose own thyroid may have been suppressed by exogenous thyroid therapy. The tri-iodothyronine (T^3) inhibition test has helped in separating the euthyroid patient with a 40 to 55 per cent 24-hour uptake from the truly hyperthyroid patient with the same borderline high uptake value. The scintigram (or gammagram) has proved of value in the demonstration of overactive ("hot") nodules and in the demonstration of functioning metastatic thyroid carcinoma when it is present.

In the large, nodular goiter, a combination of PBI or BMR with radioiodine uptake studies is preferred. In the toxic nodular goiter, the radioiodine uptake was of little, if any, value. Our results would agree with those of others,[4] who found that none of the I^{131} tests was even 50 per cent accurate in toxic nodular goiters.

In our hands, the PBI has proved the most reliable test for the functional evaluation of both (1) the toxic nodular goiter and (2) hypothyroidism. The previous (often undisclosed) use of iodides or radiopaque dyes, as well as of estrogens, is a major handicap in the evaluation of the PBI. The radioiodine uptake studies appear to be distorted for a lesser period of time than the PBI after the use of organic iodides. The BMR is still of value in these complex situations involving the questionable use of a previous drug and in following a patient's progress under treatment. The BMR usually correlates better with the *degree* of hyperfunction or hypofunction than any of the other diagnostic tests. The cholesterol level is of no diagnostic value in hyperthyroidism and is of very little value in hypothyroidism. Our experience with other thyroid function tests has been too meager to assess their value.

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Observations On The Clinical Use Of The S G O Transaminase Test

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SGOT is an aid in diagnosis of acute myocardial infarction. Many causes produce elevated transaminase levels. Careful total clinical appraisal remains mandatory for accurate diagnosis.

THE Glutamic Oxalacetic Transaminase Test is a serum test which measures enzyme activity. First introduced into the medical literature in 1955,[7,8] the test has been rapidly adopted into clinical use. Many papers have appeared describing this serum enzyme activity in various pathological states.[10,11,12] Two enzyme tests, Serum Glutamic Oxalacetic and Serum Glutamic Pyruvic Transaminase, have been found to have clinical application. We will consider here only the Serum Glutamic Oxalacetic Transaminase (S G O T) which has had wider clinical use.

S G O T activity of cardiac, diaphragm, and skeletal muscle, liver, and pancreas tissues is many times greater than that of normal serum. Physical injury and a variety of chemicals and diseases liberate enzyme from these tissues in quantity sufficient to produce characteristic serum elevations.

Wroblewski's review in the December, 1959 American Journal of Medicine,[13] lists 186 references on the subject of transaminase activity. In acute necrosis of the above mentioned tissues, fairly characteristic elevations occur above the normal serum level of 20 to 40 S G O T units per ml. per minute. Transmural myocardial infarction produces elevation for one to five days with a peak of two to fifteen fold increase. Carbon tetrachloride hepatitis and acute viral hepatitis during the increasing jaundice phase are associated with levels ranging from 500 to 2000 units and above. Alcoholic, biliary and cardiac cirrhosis in the progressive stage are associated with levels in the range of 300 units or less. Muscular trauma and muscle wasting diseases also produce low grade serum transaminase elevation. Several drugs may cause elevation, such as chlorpromazine (Thorazine®), Marsilid,® Dicumarol,® Kynex,® aspirin and codeine, especially in some cholecystectomized patients.[3,9,14]

The test for transaminase activity in the serum is simple and easily performed in general hospitals.[2,6] Figure 1 reproduced from West and Zimmerman,[12] shows the reaction used in the test.

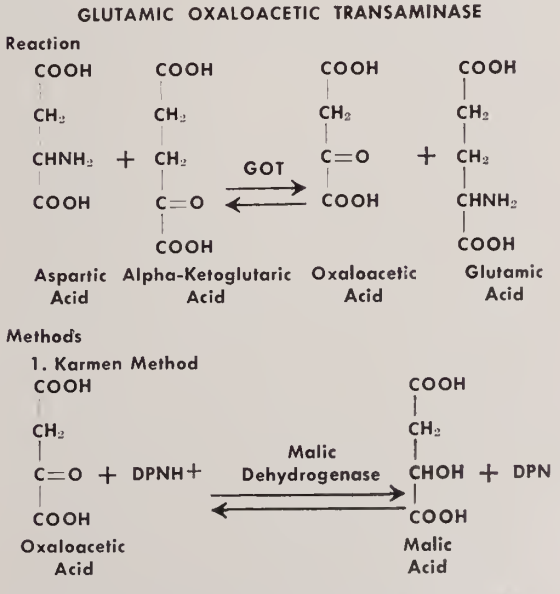


Figure 1.

The alpha amino group of aspartic acid is

transferred to the alpha keto position of alpha Keto-glutaric acid in the presence of glutamic oxalacetic transaminase, yielding glutamic acid and oxalacetic acid. The latter is further reacted with DPNH or reduced diphosphopyridine nucleotide (a nicotinic acid derivative). By this method the spectrophotometric disappearance rate of DPNH is the measure of S G O T activity.

Several of the compounds in these reactions are components of the Krebs citric acid cycle of cell respiration.[2]

The only two non-reversible reactions in the Krebs cycle involve thiamine or cocarboxylase. Cocarboxylase is necessary for activation of the splitting out of CO_2 both in the pyruvic acid to citric acid reaction, and the alpha-Keto glutaric acid to succinyl COA reaction.[6]

Thiamine Administration

The possible effect that increased thiamine administration would have on transaminase levels was brought to mind by two patients admitted to the hospital with complaints of chest pain and weakness. Prolonged moderate S G O T elevation raised the question of several possible diagnoses. Both patients had received thiamine. This suggested the possibility that an increased rate of cell respiration producing increased amounts of the substrates for the transaminase reaction and consequent elevation of serum enzyme activity could be induced by an excess of thiamine or cocarboxylase.[4, 5]

Figure 2, Case No. 9 was that of a 52-year-old automobile salesman, who had previously been a master brewer. Increasing exertional weakness, tremor, nervousness and chest distress culminated in semi-collapse. ECG changes compatible with subendocardial infarction and S G O T level of 80 units were found on admission. He also had a familial history compatible with coronary sclerosis, and a daily consumption of six to eight highballs. Hepatomegaly and psoriasis were found on physical examination. Chest and cardiovascular examinations were not diagnostic.

Borderline liver function studies were obtained. The liver decreased in size on diuretic therapy. The S G O T pattern rose and fell as is characteristic in myocardial infarction. Anticoagulants and multivitamins were included in therapy. Antibiotics were given for renal tract

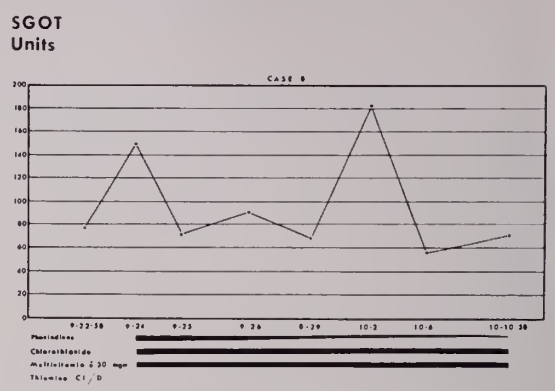


Fig. 2

infection.

Gradual clinical improvement followed, except that further transaminase studies remained elevated and subsequently increased while the patient diuresed fifteen lbs. Significant firm hepatomegaly remained and his BSP test became elevated. Although deep Q wave electrocardiographic changes did not occur, we chose to believe this patient had a subendocardial infarction, cardiac insufficiency and cirrhosis, (probably Laennec's and cardiac) with incidental prostatic calculi, urinary tract infection and psoriasis.

The second case, labelled #11, (Fig. 3) is that of a 44-year-old salesman for a large corporation who presented at the emergency room with acute, substernal chest pain, extremity weakness and dyspnea. This patient's father had died suddenly, supposedly of coronary occlusion at age 65. The patient gave a past history of pneumonitis and pleurisy. The ECG was within normal limits with a transient change in T-wave amplitude. S G O T levels were initially 58 and 55, then rose. Thiamine chloride was given to enhance appetite. Phenindione was given briefly because recurring

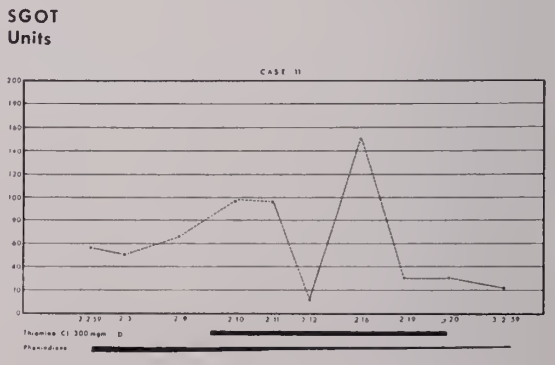
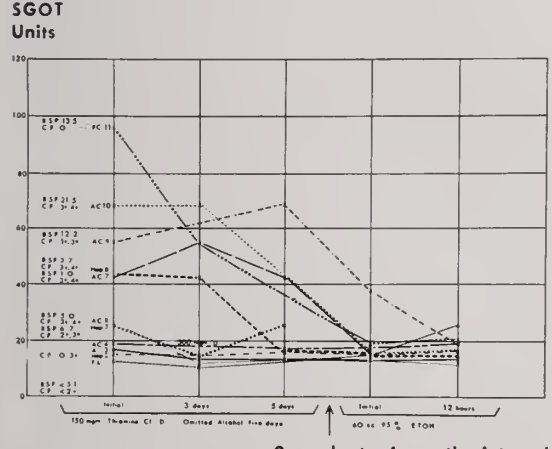


Fig. 3

chest pain seemed to be cardiac and was relieved by nitroglycerin. Of nine early S G O T determinations only two were within normal range. This patient had no hepatomegaly or history of liver disease. Liver function tests were normal. Finally, a definite pattern of intercostal or radicular neuritis appeared and with ECGs remaining normal and prolonged S G O T elevation unexplained a diagnosis of intercostal neuritis and dehydration was made. Subsequent S G O T was normal, as was the Master's Two-Step Test.

A Clinical Trial

These two cases suggested the possibility that some medication, possibly thiamine or phenindione, may have had some effect on the transaminase level. A small clinical trial for thiamine effect on the S G O T was planned. Eleven patients were selected who had previously demonstrated clinical manifestations of alcoholic cirrhosis, hepatitis, fatty liver or alcoholism. The above two cases were included in figure 4.



A Alcoholism
AC Alcoholic Cirrhosis
Hep Hepatitis
FL Fatty Liver
?C Probable Cirrhosis

Figure 4.

A very brief liver function profile consisting of BSP test (5 mgm. dye/Kg. body weight), cephalin flocculation, and S G O T test was done. Five patients had S G O T elevations above 40 S G O T units per milliliter per minute. Two of these were borderline at 42 units. The three definite elevations correlated well with the three BSP elevations. The second case discussed above, No. 11, had an S G O T of 96 and a BSP of 13.5 mgm % about fifteen months after his S G O T elevations during hospitalization.

All patients were given a card requesting that no alcohol be used for five days. A 50 mgm tablet of thiamine chloride was given t.i.d. after meals for four days with S G O T determinations repeated on the third and fifth day.

Of the five initially elevated S G O T determinations, three fell, one increased, and one rose and returned to the same level. From the comments of the patients, I suspected the omission of alcohol may have been a factor. The only conclusion about thiamine one could assume is that this dosage of thiamine does not cause an S G O T level increase in most patients under these conditions.

Bang, Iversen, Jagt and Madsen studied S G O T activity in acute and chronic alcoholics in Copenhagen.[2] They reported 80% of 39 chronic alcoholics exhibited a significant and characteristic rise in S G O T activity after acute alcoholic intoxication. Figure 5, reproduced from their report shows S G O T elevations by another method reported as millimoles of pyruvic acid per milliliter per hour.

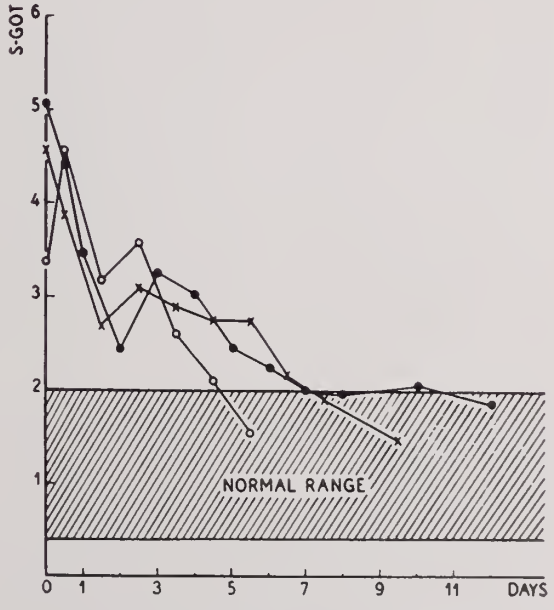


Figure 5. Serum glutamic oxalecetic transaminase activity after acute alcohol intoxication in three chronic alcoholics.

These patients were known alcoholics of ten (10) years duration, without chemical evidence of liver disease who were admitted for

treatment of intoxication in Copenhagen. The BSP test was not done. Of three livers biopsied, two showed slight fatty infiltration. You will note a two to three fold S G O T elevation in the three patients in this illustration. These authors tested twelve healthy volunteers and nineteen disulfram treated previous alcoholics and found no S G O T elevation after ingestion of 200 cc of 45% alcohol.

Bang and associates found similar S G O T elevations following 100 and 135 gram doses of alcohol in a chronic alcoholic during his admission for treatment of acute intoxication. Alcohol given on the 12th and 34th days of admission was followed by transaminase elevation.

The eleven patients in our series were very cooperative and were curious about the test results. Those that had elevated S G O T levels were told that the elevation may have been caused by alcohol, and they were asked to omit alcohol for the remaining test period.

Results

At intervals varying from three weeks to several months, ten of the eleven patients were asked to undergo another S G O T test and consume an unknown liquid after supper, then have a final S G O T determination the following morning. The unknown liquid contained 60 cc of 95% alcohol and coloring agent. The results are shown in the last two columns of Figure 4. There was no initial S G O T elevation above 40 S G O T units and no elevation occurred in twelve hours after ingestion of 60 cc of alcohol. None of these patients had a recent history of alcohol intoxication. In one case tested, the BSP fell from 12.2 to 6.7 mgm% during an interval of three months. (#9, Fig. 4). One patient failed to obtain the final S G O T test.

From this small series no concrete conclusion can be drawn. The implication is that regular moderate use of alcohol may produce elevation of S G O T in some patients who previously had liver disease. In such persons after an interval of abstinence, an isolated single dose of 60 cc of alcohol did not produce S G O T elevation after twelve hours.

The question of phenindione as a factor in transaminase elevation deserves study as Dicumarol and Tromexan,® other prothrombin antagonists, can produce low grade S G O T elevation in certain people.[14]

The transaminase test has proved to be a very useful determination when correlated with the clinical status of the patient. Significant skeletal muscle trauma, cardiac, thoracic and biliary tract surgery produce significant, but usually brief elevations.[10] Biliary fistula produces prolonged elevation, as does biliary cirrhosis unless obstruction is relieved.[12, 21]

In myocardial infarction, involvement of only 1 gm. of myocardium may be reflected by a modest rise in S G O T. Three days of testing usually catches the peak elevation unless extension of infarction occurs later. A peak elevation of over 300 S G O T units, due solely to myocardial infarction, has been associated with poor prognosis. A lower elevation does not necessarily imply a good prognosis.

The last illustration (Fig. 6), from Wroblewski's review, shows S G O T levels found in various disease states.[13]

RANGE OF SGO-T AND SGP-T VALUES IN DISEASE STATES

Disease States	Range of SGO-T Activity*	Range of SGP-T Activity*
Normal range	8—40	5—35
Transmural myocardial infarction	50—600	5—150
Subendocardial infarction	20—150	5—50
Viral and/or homologous serum hepatitis		
Non-icteric phase	50—300	60—400
Increasing icteric phase	500—2500	600—3500
Toxic hepatitis	50—27,000	50—20,000
Laennec's cirrhosis, progressive	50—250	30—200
Biliary cirrhosis, progressive	50—350	30—300
Extrahepatic biliary tract obstruction	40—300	50—400
Metastatic and primary hepatic carcinoma	40—250	20—150
Skeletal muscle trauma	30—500	20—150
Progressive muscular dystrophy, Pseudohypertrophic muscular dystrophy, Dermatomyositis	40—250	20—100

*Spectrophotometric units.

Figure 6.

The test is of special value in the differential diagnosis of chest pain,[22,17] in determining early severe cases of viral and toxic hepatitis, and progressive cirrhosis and may prove valuable in the muscular diseases. It is obvious that a good clinical appraisal of the patient, including accurate and thorough history and physical, will be necessary to interpret test

results properly in many cases. The same holds true for most tests and the fact that one must do some thinking should not deter one from using this important tool in appropriate cases.

Summary

In summary, eleven cases of previous hepatic disease or alcoholism were given thiamine for four days. No significant elevation of S G O T occurred. Five patients had initial S G O T elevations. Subsequent S G O T test in ten of the same patients including the five with elevations demonstrated normal levels in all patients and no significant rise twelve hours after a single dose of 60 cc of 95% alcohol. It is inferred that cessation of regular use of alcohol in these patients with previous hepatic pathology was responsible for the decrease in S G O T. Proving the inference and assigning significance would require longer study of a larger group.

Addendum to Observations on the Clinical Use of the S G O Transaminase Test

Several significant references regarding S G O T have appeared since submission of the above paper. Of greatest importance are several studies corroborating the significant increase in S G O T during acute right heart failure. Richman et al report 48% elevation in acute and 5% in chronic right heart failure. Elevations tend to fall in a few days as failure improves or stabilizes. Most of the increases were in the range between 40 and 80 units except in rheumatic heart disease, tricuspid insufficiency and cor pulmonale where levels between 500 and 1500 units were not unusual.[24, 25]

S G O T elevations have been reported in dissecting aneurysm of the aorta associated with cardiac tamponade. A review of earlier case reports suggests that cardiac tamponade may be a requisite for significant S G O T elevation in this disorder.[15,18]

S G O T elevation has been reported in a small percentage of patients having pulmonary embolus. Many of the more significant elevations have proved to be in cases of massive hemorrhagic pulmonary infarction.[16,17]

The interested reader is referred to the literature for the use of S G O T in differential diagnosis of neonatal jaundice[19, 20] and for possible aid in early detection of brain atrophy and other organic pathology by C S F Transaminase elevation above 10 units.[23]

This enzyme test remains quite helpful in differential diagnosis but does not replace careful clinical appraisal by history, physical and other laboratory aids.

Laboratory studies for Figure #4 were performed through the generosity of Dr. Cummings, Pathologist, and Sister Philonilla, Supervisor of Laboratories at St. Anthony Hospital, Louisville, Kentucky.

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Surgical Treatment Of Postinfarction Aneurysms

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Postinfarction aneurysms of the heart can now be successfully treated by utilizing "open techniques" with complete cardiopulmonary bypass. Such a case is reported in detail.

THE occasional development of an aneurysm of the ventricle following a myocardial infarction has been recognized for many years.[2, 11] While not the sole cause of ventricular aneurysms, myocardial infarction is by far the most common etiologic factor.[1] The actual incidence of aneurysms in cases of myocardial infarction has been estimated from as low as five per cent by some authors to as high as thirty-eight per cent by others.[1, 12] Less common types of ventricular aneurysms are those resulting from trauma, either penetrating or non-penetrating, inadequately repaired surgical incisions, and those following infections, either pyogenic or granulomatous.

Postinfarction aneurysms are usually located in the left ventricle, either near the apex or on its anterior or anterolateral aspect. An aneurysm involving primarily the posterior aspect of the left ventricle has been noted occasionally and the much rarer occurrence of an aneurysm involving the right ventricle has been reported.[1]

Several factors have been incriminated in the etiology of postinfarction aneurysms, namely, involvement of the full thickness of the ventricular musculature by the infarction, the presence of associated systemic hypertension, and inadequate bed rest at the time of the initial infarction.[12]

Various types of healing have been observed in the wall of the aneurysms, ranging from dense fibrous connective tissue of variable thickness to some cases exhibiting calcifications and rarely, bone formation.[5] A mural thrombus commonly lines the wall of the aneurysm. The overall size of the aneurysms differs markedly, sometimes being only large enough to alter the contour of the cardiac silhouette and at other times being almost as large as a normal-sized heart itself. Small ventricular aneurysms may be asymptomatic whereas significantly sized ones lead to progressive cardiac disability and ultimate death, often within a matter of months.

The mechanism whereby an aneurysm may produce disability or even death is often unpredictable. Large aneurysms usually cause a reduction in cardiac output[7, 14] with the resultant cardiac decompensation often proving refractory to treatment. Others may give rise to serious or even fatal embolic phenomena as fragments of the mural thrombus are extruded into the ventricular chamber proper and thence into the systemic circulation. Frank rupture of the aneurysm with death due to cardiac tamponade or exsanguination is surprisingly uncommon.[12]

Development of Surgical Treatment

The first successful attempt at surgical correction of a ventricular aneurysm was made in 1931 by Sauerbruch.[11] In 1942 Beck[2] attempted to correct a postinfarction aneurysm by utilizing fascial sutures to strengthen the aneurysmal wall but the patient succumbed as the result of secondary infection. The first successful correction of a postinfarction aneurysm was carried out by Bailey in 1954.[1] Bailey utilized a closed technique, clamping the base of the aneurysm and excising the tissue distal to it and then oversewing the cut margins. Sub-

sequently he modified this technique to include "flushing" of the aneurysm[1] through an incision in its summit prior to clamping the base in order that any clot present might pass out through the opening during ventricular systole thus averting embolization. More recently he has adopted the present day operative approach developed by Cooley[4] in 1958, namely open correction of the aneurysm while employing temporary cardiopulmonary bypass. Cooley[5] recently reported his experiences with ten cases with only two deaths. By employing any one of several satisfactory pump-oxygenators one can avoid the dangers of embolization and can perform a more accurate and precise excision and repair of the aneurysm while affording maximal protection to vital intracardiac structures. Merendino[10] emphasized the need for cross clamping the aortic root prior to manipulating or incising the aneurysm after observing the occurence of fatal embolization with an open technique.

The optimum time for surgical correction of a postinfarction aneurysm is probably about three months after the initial infarction. The development of sufficient fibrous connective tissue in the base of the aneurysm facilitates the placement of sutures to repair the ventricle and is well advanced at this time. Experiences of others[5] in attempting to suture the ventricular wall during the earlier stages of healing after infarction have been unsatisfactory. However, if the patient's condition is such that operation cannot be delayed, surgical correction should be attempted as a life saving procedure regardless of the time interval, although the risk will be greatly increased.

The average age of those patients operated upon was about 55. There were only two females in the group of 22 patients.

The following is a case of a 41 year old white male with a huge postinfarction aneurysm which continued to enlarge up until the day of surgery and which reduced cardiac output to the point that the patient remained in border-line congestive failure even on minimal physical activity and while receiving maximal medical therapy.

Case Report

W.T.P., a 41 year old white male was first admitted to the Kentucky Baptist Hospital on March 9, 1960, complaining of severe chest pain which developed after shoveling snow and then eating his evening meal. His initial ECG revealed an anterior septal infarct and three days later a repeat ECG revealed extension of the infarction laterally and posteriorly. A loud pericardial rub was present and persist-

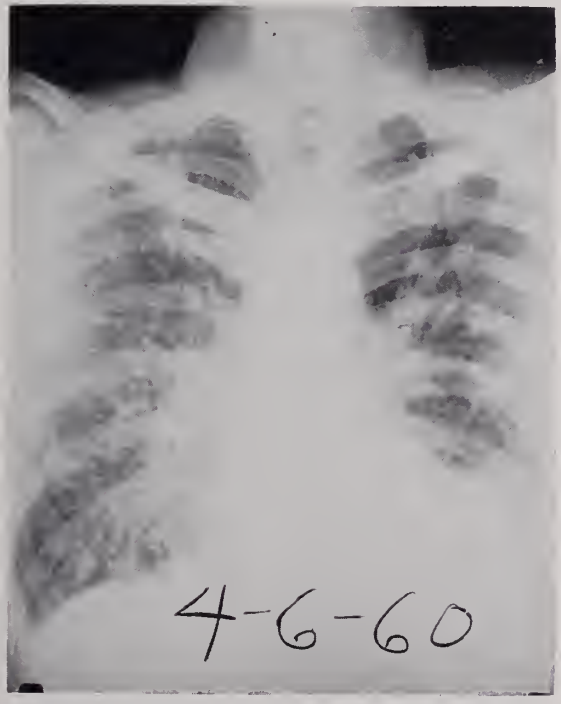


Figure 1. Roentgenogram approximately one month after myocardial infarction.

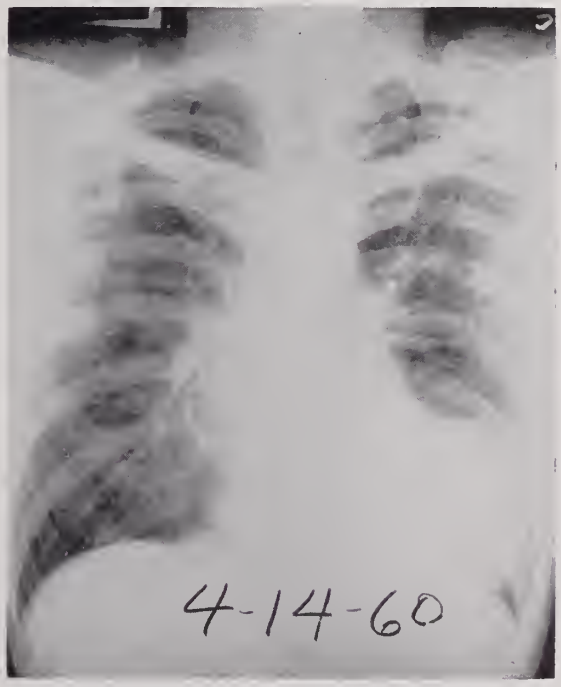


Figure 2. Roentgenogram approximately five weeks after infarction, showing further enlargement of the aneurysm.

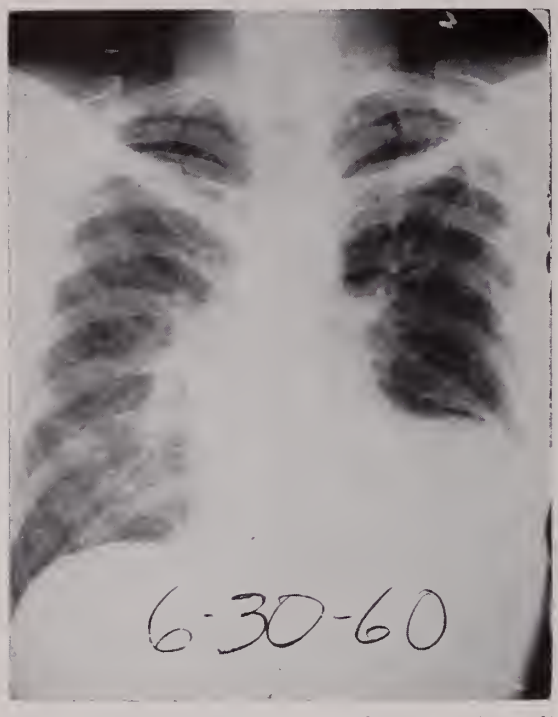


Figure 3. Roentgenogram approximately three and a half months following infarction reveals huge ventricular aneurysm extending out to lateral chest wall.

ed as did his fever, leucocytosis and pain. His P.M.I. was noted to have shifted out towards the axilla and clinically he was thought to be developing an aneurysm. This was confirmed by x-ray examination approximately one month following his admission. Anticoagulant therapy was instituted on admission and maintained. He was discharged from the hospital approximately five weeks after admission, having been digitalized, and having been placed on diuretics and salt restriction as well as marked limitation of activity. Repeat x-rays of the chest at time of discharge revealed further enlargement of the aneurysm along with increased pulmonary congestion.

He was re-admitted to the hospital on June 30, 1960, at which time his P.M.I. was noted to be in the mid axillary line and x-rays revealed additional enlargement of the aneurysm. On July 2, 1960, the patient was taken to the operating room where he was anesthetized with Sodium Pentothal® and nitrous oxide plus Anectine® and an endotracheal tube passed. These agents were employed throughout the procedure in order to maintain light but satisfactory depth of anesthesia. The left femoral artery was exposed for the arterial inflow cannula and the left brachial vessels prepared for insertion of catheters for monitoring central venous pressure and central aortic pressure. The chest was entered through an anterior thoracotomy incision, utilizing the right fourth and the left fifth intercostal spaces, transecting the sternum with a Gigli saw. Because of the huge size of the aneurysm and the fact that its wall appeared so thin, heparinization was achieved by administering approximately 3 mgs. heparin per Kg of body weight and large polyethylene catheters were inserted into the superior and inferior vena cavae via the right atrial appendage in order that cardiopulmonary bypass could be instituted promptly if necessary. The inflow catheter was positioned in the left femoral artery, as were the catheters in the brachial vessels. The pericardium was then carefully dissected off the aneurysm. Over the apex of the aneurysm dense vascular adhesions were noted extending from the pericardium to the aneurysm. In this area the aneurysm wall was no greater than a millimeter in thickness. The aneurysm was inadvertently perforated as the final portion of the pericardium was reflected. The aortic root was clamped, the vena cavae occluded and cardiopulmonary bypass promptly instituted, using a modified Kay-Cross disc oxygenator* with a flow of approximately 4 liters per minute. The left phrenic nerve was transected while freeing the pericardial adhesions over the lateral aspect of the aneurysm. It was subsequently approximated with fine silk sutures. The aneurysm was widely excised back to its fibrous base. Significant mural thrombus was strikingly lacking and thought due to the prompt institution and maintenance of anticoagulant therapy at the time of the initial infarction. No pulsations could be seen or felt in the interventricular sulcus over the course of the anterior descending branch of the left coronary artery. After excision of the aneurysm the ventricular wall was approximated with continuous suture of #1 silk on an atraumatic needle and additional reinforcing sutures of 000 silk were used as needed. The completed suture line extended from the A-V sulcus down and around the apex of the ventricle and for a distance of several centimeters onto the posterior wall of the ventricle.

**Basic unit manufactured by Pemco Inc., Cleveland, Ohio, and subsequently modified by the authors.*



Figure 4. Disc-oxygenator manufactured by Pemco Inc., Cleveland, Ohio, and modified by the authors.

The pericardium was approximated over the anterior aspect of the ventricle and left open laterally and posteriorly for drainage. Intermittent aortic occlusion was used during the bypass. Upon release of the caval snares and discontinuance of the cardiopulmonary bypass the heart promptly maintained an effective output. The caval catheters were removed and the incisions in the atrial appendage repaired. Neutralization of the heparin was achieved with fractional doses of Polybrene®. The femoral artery was repaired with 00000 silk after first removing the inflow catheter. Each pleural space was drained with a large bore polyethylene catheter and the sternum was approximated with interrupted stainless steel wire sutures and the skin with continuous silk sutures. The monitoring catheters were removed from the brachial vessels and the artery was reconstructed and the vein sacrificed. The arm and groin incisions were closed with silk sutures. Upon completion of the wound closures the patient's vital signs were very stabile and he was beginning to react. Each chest catheter was attached to water seal drainage and he was transferred to the recovery room. His ECG (lead I) was monitored throughout the procedure and was remarkably stabile and on completion of the

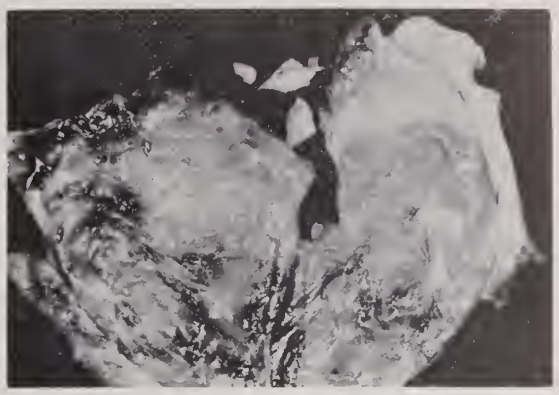


Figure 5. Specimen of the excised aneurysm measuring approximately 15 by 15 cm.

ventricular repair an R wave reappeared. Because of the injury to the left phrenic nerve it was decided to perform a tracheotomy. This was done under local anesthesia in the recovery room. Following tracheotomy the patient was able to ventilate more satisfactorily. The patient was kept in the recovery room for the first 24 hours postoperatively and then transferred to his room.

His early postoperative course was marred by fever, mucopurulent tracheal secretions and hypoprothrombinemia. Hedulin® therapy was resumed on the second postoperative day and subsequently discontinued because of hematuria, some gross blood in the tracheal secretions and a prothrombim level of 40.5 seconds on the third and fourth postoperative days. Chloromycetin was given intramuscularly. On the night of the fifth postoperative day following the use of IPPB to help clear his secretions a varying supra-ventricular and ventricular tachycardia developed. Cedilanid®, quinidine, Pronestyl® and Neo-synephrine® were all used with little improvement. A slow Levophed® drip was begun because of the associated hypotension and maintained for 24 hours and then discontinued. The tachycardia promptly disappeared when the Levophed® was started and did not recur. The following day he developed purulent drainage from the sternal portion of the incision and subsequently the sternal wires were removed and the central portion of the wound packed open and permitted to heal secondarily. No additional digitalis was given after the ventricular tachycardia was initially controlled. His postoperative course was then one of progressive improvement. The tracheotomy tube was removed on the 16th postoper-



Figure 6. Roentgenogram of patient approximately nine months after excision of ventricular aneurysm showing striking reduction in size of cardiac silhouette. Elevation of the left leaf of the diaphragm is still present.

ative day and the patient was discharged on the 20th postoperative day, freely ambulatory, taking a regular diet, without medications and with a normal sinus rhythm.

His subsequent course has been one of continued improvement. His x-rays (Fig. 6) have revealed a striking reduction in his heart size and overall cardiac configuration. He has returned to fulltime work as a surveyor's assistant, asymptomatic and without medication (Fig. 7).

Summary

Aneurysms of the ventricle resulting from myocardial infarction are occasionally encountered. These aneurysms may be quite small and of little clinical importance or they may be of sufficient size so as to be extremely disabling either because of reduction of left ventricular output or because of embolization arising from the mural thrombi. Rarely does frank rupture of the aneurysm occur. Symptomatic aneurysms may be successfully corrected by surgery utilizing temporary cardiopulmonary bypass as has been developed for other cardiac lesions.[6,8] The surgical experiences of others[1,2,3,4,5,7,10,11,13,14] is briefly reviewed and a case of a 41 year old white male with a huge ventricular aneurysm that was successfully treated is described in detail.



Figure 7. Photograph of patient showing bilateral incision that was utilized.

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Volvulus of the Cecum or Proximal Colon*

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Cecal volvulus, not rare, may be overlooked often. Flat X-ray film of abdomen usually diagnostic in acute form. Treatment is prompt laparotomy, detorsion.

Incidence

VOLVULUS of the cecum, or more accurately, of the proximal colon,[9,24] accounts for only one per cent of all intestinal obstructions. Despite this and despite the fact that, since 1839,[19] less than 500 cases have been reported in the English-American literature, cecal volvulus is almost certainly not a rare condition, many cases being either unrecognized or unreported.[4,6,24,25,26] Lack of recognition can be due to the fact that attacks of cecal volvulus can be mild, nondescript, and spontaneously resolving, earning the incorrect diagnosis of appendicitis, cecitis, ileocolitis, etc. The reported ten to twenty per cent incidence of mobile cecum in the general population further suggests that many cases are unrecognized or unreported, since abnormal cecal mobility is a fundamental prerequisite for the development of volvulus.[1,2,4,10,11,14,24]

Age and Incidence

Whereas mobile cecum is more common in the female, most observers feel that volvulus is more common in the male. Cecal volvulus is encountered most frequently in young adult males but occasional cases have been reported in children; where it is usually a part of, or secondary to intestinal malrotation or non-rotation; and in the aged.[3,4,11,24,29]

Etiology

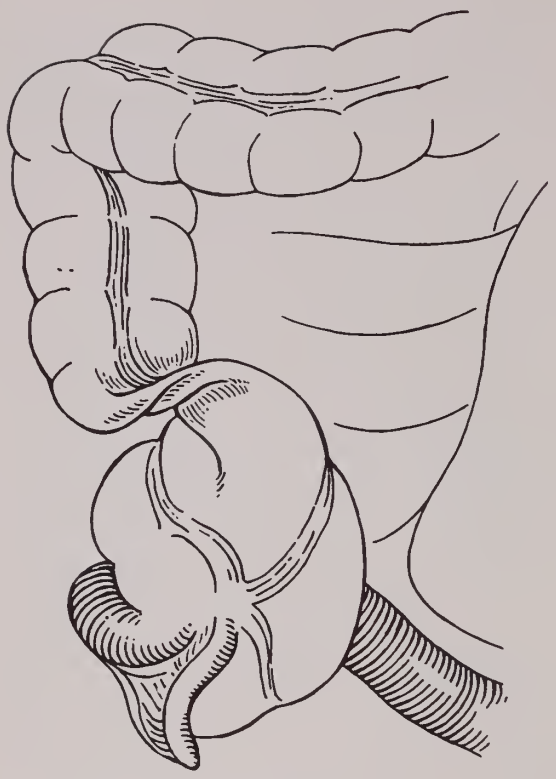
The anatomic prerequisite for cecal volvulus is congenital abnormal mobility of the cecum, with a fixed point in the distal right colon, (Fig. 4) around which the volvulus pivots.[24] To this must apparently be added singly or in combination, one or more of the following activating factors:

(1) Violent muscular effort.[4,11,24]
(2) Vigorous peristalsis. (Heavy meal, purgation, distal colonic obstruction.)[18,28,30]
(3) Rapid changes in intra-abdominal relations and dynamics. (Pregnancy, parturition, abdominal operation, the post-operative status.)[7,8,11,12,20,27,28]
(4) Acute abdominal inflammation or peritoneal irritability.[5,28]
(5) Effects of prior abdominal operations, adhesions, etc.[11,24]
(6) Congenital abnormalities of intestinal rotation, i.e.,[3,13,29] "reversed" rotation, non-rotation, incomplete rotation.

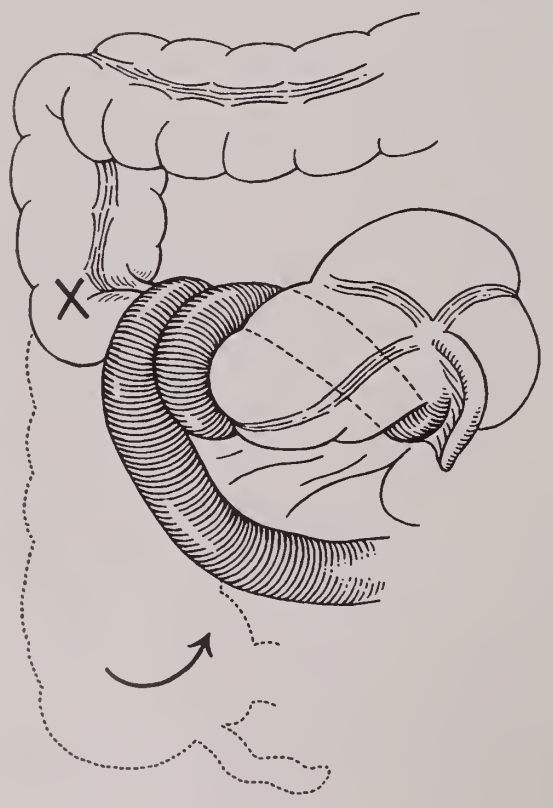
Recently, Ritvo and his associates have stressed the association of volvulus of the cecum wih distal colonic lesions.[18] Fifty per cent of Ritvo's cases had such an association, among them two cases of diverticulitis, one case of carcinoma of the descending colon, one carcinoma of the sigmoid, one carcinoma of the rectum, and one case of benign rectal stricture.

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1-a



1-b

Figure 1. (Redrawn from Villet, 24) Types of Cecal Volvulus: (a) Radial type, (b) Loop type (X designates fixed pivotal point). Compare with Figure 5.

Pathologic Anatomy

Two mechanical types of volvulus of the cecum have been described;[15,24]

(1) Loop type.

(2) Axial type. (Fig. 1)

Of the two, the latter is the more uncommon and is thought to be produced whenever a pre-existing abdominal adhesion prevents the migration of the twisting cecum from its normal right-sided position. Interesting arguments exist as to whether the twist of cecal volvulus is characteristically clockwise or anti-clockwise. Further confusion is added by the failure of various surgeons to note at operation whether the twist is clockwise with respect to the patient or the observer.[4]

The tightness rather than the number of twists or their direction, determines the amount of vascular occlusion and subsequent gangrene of the segment involved, as well as the degree of intestinal obstruction produced by the volvulus. Hence, with two or three very loose twists, it is entirely possible for the viability of the segment to be preserved and only a low grade of intestinal obstruction to be produced.

The cecum and adjacent colon are usually tremendously distended and create a mass, usually palpable, which may lie in any of the abdominal quadrants, though usually in or near the left upper quadrant of the abdomen. Because of the extreme distention and the interference with blood supply, patches of hemorrhage, infarction and gangrene over the surface of the greatly distended bowel are commonly seen. Even without circulatory interference, it is common to find linear slits or ruptures of the seromuscular layers, due to the tremendous distention. (Fig. 5) It is important to realize that cecal volvulus is in reality a closed-loop obstruction.

Symptoms and Signs

Ingelfinger[10] has shown that in volvulus of the cecum, a rotation exceeding 180 degrees must be obtained before symptoms of colic develop. He made the further valuable observation that in many individuals, it was entirely possible to have a recurring type of cecal volvulus, perhaps with a rotation of slightly more than 180 degrees, producing mild colicky symptoms, which subsided completely, only to

FOR CORRECTION SEE page 145

recur in the future. It is this type of case which is not recognized as volvulus or perhaps is operated upon under a mistaken diagnosis of recurring appendicitis.

Generally speaking, the picture of cecal volvulus is that of a low small bowel obstruction. Various degrees of severity have been recognized and cases of cecal volvulus have been categorized as follows:[2,10,21,22,24]

(1) *Fulminating*: Rapid progression of symptoms of an abdominal crisis or catastrophe with early collapse and death in a few hours' time.

(2) *Acute*: Severe obstructive manifestations, with signs of an acute surgical abdomen.

(3) *Chronic*: Vague nondescript picture of recurring abdominal distress, with spontaneous resolution, intervals of remission, and recurrence.

Usually a mass can be felt, which, originating in the right iliac fossa, extends towards the navel, and may lie predominantly in the left abdomen. This mass which represents the distended cecum and adjacent colon, may be found in any of the abdominal quadrants, most commonly in the left upper quadrant, unless previous intra-abdominal adhesions or attachments modify the picture. In the axial type of volvulus previously described, the distended cecum is restrained in its right lower quadrant position by an adherent appendix or other adhesions. The distended cecal mass may be only slightly tender, or may be extremely tender, due to imminent perforation, leakage, and local peritoneal irritation. If perforation has occurred, the signs of an early spreading peritonitis may also be present.

It must always be borne in mind that, in the acute and fulminating forms of the disease, a closed-loop type of obstruction with all the lethal potentialities of such a condition, is present in the abdomen.

Diagnosis

Diagnosis of cecal volvulus rests on a triad of signs as follows:

(1) *History*—Resembling low small bowel obstruction.

(2) *Abdominal Mass*— Tympanitic, with tenderness varying from slight to severe.

(3) *Roentgen Findings*—

a. A large distended viscus which may be in any abdominal quadrant, more frequently in the left upper quadrant.

b. Distended small bowel loop*s to right* of apparent cecum.

c. Notch or V of ileocecal valve *to the right* of the cecum.

Differentiation from acute severe (Fig. 2, 3) gastric dilatation is readily made by the introduction of a Levin tube which fails to decompress the distended viscus. (Fig. 2, 3) Differentiation from sigmoid volvulus, which may closely resemble volvulus of the cecum clinically,[15,16,17] can usually be made by noting that in the case of the former, the distended loops of proximal bowel seen are colonic; while in the case of cecal volvulus they are ileal or jejunal loops. A barium enema will readily demonstrate the normal sigmoid and often the point of fixation or twisting in the distal right colon itself. (Fig. 4) Usually the flat films of the abdomen are sufficiently diagnostic to preclude the necessity of either intubation or



Figure 2. Cecal Volvulus. Note small bowel shadow below and to observer's left of distended cecum. Note Levin tube fails to decompress. Arrow points to ileocecal "notch." Compare with Figure 5.

barium enema.[4,6,15,18,21,24]

Ingelfinger[10] has demonstrated a valuable diagnostic technique in cases of mild, unrecognizable, recurring cecal volvulus. He advocates delineation of the cecum by means of barium, introduced through a long intestinal tube, the tip of which has been passed into the cecum. Positioning and manipulation of the patient will then demonstrate that the barium filled cecum is abnormally mobile, and may actually reproduce the volvulus, as in Ingelfinger's case. By such means, patients with nondescript abdominal colic or pain due to unrecognized cecal volvulus may be detected, and surgical correction instituted as an elective or prophylactic measure.

Treatment

The treatment of cecal volvulus is obvious. Ideally, it consists of surgical intervention and detorsion of the volvulus, before perforation or other irreversible changes have developed in the wall of the compromised viscus.

Pre-Operative Preparation

Before laparotomy, a short time may well be spent in correcting any electrolyte or water deficiencies or imbalances which may coexist. Preliminary gastroduodenal intubation is helpful, but time must not be spent in trying to effect decompression by this means. Obviously in the face of a closed-loop obstruction it will be unavailing. If the patient is in shock, rapid transfusion of blood begun on the ward and continued in the operating room is mandatory but a therapeutic effort to get the patient out of shock by blood transfusion and various other means, should not delay the inevitable laparotomy.

Operation

a. *Incision*: Either a vertical or a transverse incision may be used depending on the position of the mass as determined by palpation or x-ray studies. It is well to remember that the basis for the condition lies in the right hemicolon and consequently any incision, whether transverse or vertical should be so placed as to give maximum or adequate exposure of this colonic segment. Any incision used should be generous in size.

b. *Detorsion*: If detorsion proves at all difficult, catastrophe may be avoided by first decompressing the tremendously distended cecum with a needle and syringe or with a trocar and suction. Great care must be taken during this maneuver to avoid spillage and splitting of the coat of the bowel.

Because of the possibility that toxic products may be released into the distal colon, during or following detorsion, some have recommended temporary occlusion by clamp or ligature, of the colon distal to the volvulus until detorsion has been accomplished and the cecum has been evacuated.

c. *Resection*: If the involved segment of colon is frankly gangrenous, resection will be necessary. If the patient's condition permits, intestinal continuity should be restored by end to end anastomosis using one layer of carefully placed mattress sutures of nonabsorbable suture material. In situations where the patient's condition is critical, exteriorization of the distal colonic stump and the proximal ileal stump as a modified Mikulicz procedure may be all that can safely be done. In other less drastic cases, resection, side to side anastomosis and exteriorization of the colonic and ileal stumps after the manner of Woodhall may be indicated.

d. *Cecal Fixation*: In those cases where simple detorsion suffices, steps must be taken to prevent recurrence of the volvulus. A variety of methods have been devised. Probably the surest and best is cecopexy by elevation of a lateral peritoneal flap which is then sutured to the outer coats of the cecum in such a manner that no orifice is left for later herniation of small bowel. In most cases, tremendous distention of the obstructed cecum has occurred and it will be wise even after operative decompression to provide drainage by a cecostomy so that any resulting paresis of cecal function will be compensated for. If the appendix is still available, simultaneous appendectomy and cecos-

tomy through the base of the appendix (modified appendicostomy) will have the advantage of not only decompressing the cecum but of actually providing fixation by adhesions, to prevent recurrence. If the appendix has previously been removed, a typical cecostomy can be done with the same results.

e. *Search for Coexisting Pathology*: Because of the frequent association in the adult of cecal volvulus with distal colonic lesions, especially neoplasm, a search begun at operation, and completed before discharge from the hospital for such an association must be carried out. This will include whatever degree of abdominal exploration is permissible at the primary operation complemented by barium enema and sigmoidoscopy in convalescence.

Mortality

Mortality figures of great variability are usually found in the literature, ranging as high as fifty per cent. Much, of course depends on the viability of the bowel and the necessity for resection. Villet, in a review of 150 cases culled from the literature since 1929, found an overall mortality rate of 21.7%. In thirty cases analyzed by this author since 1948, there were but three deaths; a mortality rate of 10%; an improvement attributable (by the author) to improved anesthesia and better surgical physiology and technology. Villet concludes that overall mortality figures should be around 15% if the bowel is intact and viable at operation, 29% if torn, split, or nonviable.[24]

Case Report

(J.B.H., age 59, patient of Morris Flexner, M.D., Louisville, Ky.) This white male polo player developed severe upper abdominal cramping pain with nausea and vomiting and a desire to belch and/or defecate, in the early morning following a hard night polo session and a late heavy meal. On admission to the hospital, eight hours after onset, examination revealed a healthy vigorous white male in excellent physical condition. Blood pressure was 120/80. The pulse was 80 and of good volume. His general appearance was excellent. He was



Figure 3. Barium outlines stomach, duodenum and several jejunal loops.



Figure 4. Barium enema outlines normal sigmoid. Arrow indicates fixed pivotal point in ascending colon.

no longer complaining of pain, but merely of a mild generalized discomfort in the upper abdomen. A tympanitic mass was palpable mainly in the left upper quadrant but it extended across to the right mid-abdomen. It was not particularly tender. Because of the mildness of



Figure 5. Findings at operation. Cecum is to observer's right, ascending colon to left, fixed point at left with turn of jejunum around it. Compare with Figures 1 and 2.

his symptoms which were in fact subsiding when he was first seen by the surgeon (GBS), a rather extensive roentgenological work-up had already been carried out although the flat film of his abdomen taken on admission was diagnostic. (Figs. 2, 3, 4) Despite his protests, he was submitted to laparotomy thirty-six hours after the onset of his illness and a tremendous volvulus of the proximal colon was found. Although there were no gangrenous patches there were several small areas of hemorrhage in the wall of the cecum and ascending colon, and several linear slits measuring 3/4 to 1 1/2 inches in length indicated beginning rupture of the bowel. Because of the fortunate location of the large transverse incision employed, it was possible to deliver the mass outside of the abdomen with ease where detorsion was carried out protected by insulating lap sponges. It was noted that three full 180 degree twists had taken place around the point of fixation in the mid-ascending colon. (Fig. 5) After complete detorsion had been effected it was seen that an apical adherence to a long medially coursing appendix had been the guiding if not the triggering factor in the volvulus. Thus, the cecum and first portion of the ascending colon up to the point of fixation had rotated in an axial manner between the point of fixation of the tip of the appendix in the left mid-abdomen, and the distal point of fixation in the ascending colon, wrapping the terminal ileum around the cecocolic junction. After the cecum had been returned to its proper position it was apparent, because of the tremendous distention and subsequent atony, that a cecostomy would be necessary for several days. The appendix was thereupon amputated flush with the cecum and through the opening in the cecum left by appendectomy, a latex rubber cecostomy tube was inserted and held in place by two concentric purse string sutures of chromic catgut. The cecostomy tube was then brought out of the abdomen through a stab wound in the right lower quadrant and the outer purse string suture of catgut was used to approximate the cecostomized cecum to the adjacent parietal peritoneum. Recovery was uneventful. Several weeks later, a negative sigmoidoscopy completed the survey of the colon which had been begun with the barium enema done preoperatively. The patient has remained well without symptoms or recurrence for eighteen months.

Summary

1. Volvulus of the cecum or proximal colon is not a rare condition.
2. Many cases of undiagnosed cecal volvulus masquerade as recurrent appendicitis, cecitis, ileocolitis, or unexplained abdominal colic. In such nondescript cases, intubation and barium instillation of the cecum may reveal the true condition and lead to prophylactic elective laparotomy and cecopexy.
3. In the majority of acute cases, a history resembling low intestinal obstruction, the finding of an abdominal mass, and characteristic x-ray findings on a simple flat x-ray film of the abdomen will establish the diagnosis.
4. The treatment is prompt laparotomy, detorsion, cecostomy and cecopexy. Resection may be necessary for gangrenous changes or perforation, and, if so, restoration of intestinal continuity may be complicated.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

New Penicillins

Arthur C. White, M.D.*

THE case for discussion is a patient with resistant staphylococcal infection who illustrates some of the advantages of new penicillin compounds.

A 22-year-old male was admitted with a chief complaint of infection of the hand.

Approximately three weeks before admission, following a cut to the left hand, a small amount of pus had drained from the site. This had healed following soaking the hand in warm water.

One week before admission a furuncle appeared over the inner aspect of the right elbow with considerable erythema. Despite surgical drainage and treatment with erythromycin, the erythema continue to spread and pain, redness, and swelling developed in the right hand.

Positive physical findings included a temperature of 101° F., a 4x6 cm. furuncle over the right elbow and marked redness, heat, pain, and swelling of the right hand extending approximately two inches above the distal end of the radius.

A phage type 80 staphylococcus was isolated from the furuncle and from material aspirated from the hand which was resistant to penicillin G, tetracycline, erythromycin, and chloramphenicol but susceptible to methicillin and Prostaphlin® (5-Methyl-3-Phenyl-4-Isoxazolyl Penicillin).

He was treated with 500 mg. orally of Prostaphlin® (5-Methyl-3-Phenyl-4-Isoxazolyl Penicillin) every four hours with rapid clearing of the lesion. Therapy was continued for ten days and there has been no recurrence of symptoms for the subsequent four weeks.

Discussion

When penicillin was first introduced a number of different penicillins were available. Because of a high degree of serum binding or lesser efficacy of other penicillins, only penicillin G (benzyl penicillin) continued to be produced until 1955. During this period, penicillin G was available as an aqueous form for injection which had to be given frequently because of rapid urinary excretion, as the procaine salt which was slowly released and therefore needed to be given only once daily, and as benzathine penicillin G (Bicillin®) which was very insoluble, released even slower than the procaine salt, and therefore gave low but persistent blood levels for two to four weeks.

A phenoxymethyl penicillin, penicillin V, was formed by fermentation in 1955 which was acid stable and therefore absorbed much more completely after oral administration than penicillin G. However, its activity against various bacterial species was almost identical to penicillin G.

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In 1959, it became possible to produce in large quantities the basic penicillin molecule 6-aminopenicillanic acid. A large number of side chains have been attached to this basic molecule to produce new penicillins. Although most of these new compounds are less active than penicillin G (benzyl penicillin), a number of new penicillins have been formed which have significant advantages over penicillin G.

The first semi-synthetic penicillin to be released for general use was alpha-phenoxyethyl penicillin with the generic name of phenethicillin and the trade names of Syncillin®, Darcil®, Maxipen® and others. This penicillin was absorbed somewhat more effectively than penicillin V after oral administration. In addition, it was somewhat more resistant to staphylococcal penicillinase than penicillin G and therefore more effective than penicillin G against resistant staphylococci *in vitro*. However, on a weight basis it is somewhat less active against pneumococci and Group A streptococci.

In 1960, dimethoxyphenyl penicillin was first released for general use. This compound has the generic name of methicillin and the trade name of Staphcillin®. It is not acid-stable and is very poorly absorbed after oral administration. However, it is highly resistant to staphylococcal penicillinase and therefore very effective against staphylococci which are penicillinase producers and thereby resistant to penicillin G. It is considerably less active than penicillin G against staphylococci which do not produce penicillinase and because it is less effective than penicillin G against pneumococci or streptococci, the indication for the use of methicillin is restricted to penicillinase-producing staphylococci. Like penicillin G, methicillin is bactericidal in action and is a significant drug in the treatment of resistant staphylococcal infections. Its main disadvantages were the need for frequent intramuscular injections because of the rapid urinary excretion and poor absorption orally.

Another penicillin (5-Methyl-3-Phenyl-4-Isoxazolyl Penicillin (Prostaphlin®) has recently been described which is also highly resistant to staphylococcal penicillinase and, in addition, is absorbed well after oral administration. Like methicillin, it is bactericidal and is more effective than penicillin G only against staphylococci which produce penicillinase. It is, however, more active on a weight basis against penicillinase-producing staphylococci than methicillin. It is less active than penicillin G against pneumococci, group A streptococci, or staphylococci which do not produce penicillinase.

The patient presented in this conference illustrates the activity of this compound orally in patients with infections due to resistant staphylococci.

A number of other penicillins are now being tested with varying antibacterial activity and pharmacology including activity against gram-negative infections which differ from that of penicillin G. Undoubtedly, there will be available for clinical use several different penicillins so that one will no longer have only penicillin G but a variety of penicillins for specific indications.

SPECIAL ARTICLES

Facts and Fiction of Medical Care*

EDWARD R. ANNIS, M.D.

Miami, Florida

IT IS A pleasure to be back in Louisville. The last time I was here my trip was a little less successful but equally enjoyable in that I met many of your fine citizens, made many new friends, but lost on my bet at the Kentucky Derby.

At the outset, however, because Doctor Long referred to previous television efforts on my part, I would like to tell you of my greatest triumph on television. My wife Betty and I are very fortunate. We have four sons and four daughters. After the Humphrey Debate, after the Senator and I had had a most enjoyable evening on the N.B.C. program "The Nation's Future," Margie, who is 12, came home from school and said: "Mother, do you know what a boy said to me in school today?" And Betty said "What did he say?" "Well, he said 'Margie, is your daddy Doctor Annis?' I said yes. 'Doctor Edward Annis?' Yes. 'And is he the doctor who was on television the other night with some senator?' Yes, that was my Daddy . . . and I was so proud."

Betty said "Well Margie, you should have been, your Daddy did a pretty good job." And Margie says "Well Mother, I know that but do you know what this boy said?" "What did he say?" "Your Daddy looks like a peeled onion."

Margie can't see the television studio but because I understand that my remarks are being televised, I will leave it to those who are watching me on television to see if Margie was right. I asked her if she thought I ought to wear one of those "things" and she said "Daddy, it might help on TV."

During the last couple of years you have heard, and the American people have heard, a great deal about our elderly citizens. Many people have devoted time and effort to look into their problems, to find out do they really have medical problems, do they have financial problems, do they have housing problems, and some of them do.

We have heard a lot about how many people are reaching the ripe old age of 65 and living longer. You have heard a lot of things, some of them true, some of them fictional, some of them reflect a story that would make you believe that all of our older people are sick and all of them poor and this isn't true, but some of our older people are sick and need help and can't afford to pay for it. These people should be cared for.

Whose Responsibility?

We think this is a just responsibility of government. But many of our older people are among the most substantial in our nation, they have not only contributed their children and their great-grandchildren to it, but in many instances they have contributed immeasurably to the growth of America. Among our most substantial citizens are those who have retired from great corporations and are therefore eligible for and receiving Social Security, but they are well able to take care of themselves and American medicine feels that these people who have done it all of their lives should continue in the future as in the past to take care of their medical needs as well as their other needs.

This is why there is an alleged question. You know, this isn't new to doctors. We have been devoting our efforts for a long time to prolonging the lives of Americans. Our efforts have been put forth to try to bring to the American people, and through them to the world, the great advances in the field of science, the contributions from the biologist, the chemists, the physicists, the electronic investigator and all of the rest, because all of these things today constitute the armamentarium of your physician.

As a result of this, people are living longer. In 1900 there were only 3,000,000 people in this country who were approaching 65 years of age and most of them only lived an extra four or five years. Today we have almost 17,000,000 people who are 65 and

**Presented over WAVE-TV, Louisville, at the close of the 1961 KSMA Annual Meeting, Thursday evening, September 21, 1961. This paper has been transcribed from a tape recording that was made of the address, and is being printed because of popular demand.*

every single day we add a thousand to that number, a thousand in excess of deaths and these thousand people and those who are living with them can expect an average life expectancy of at least 15 more years.

So, we are very proud of medicine's contribution to the longevity of Americans and we hope that all of you will live long to enjoy it. We are constantly striving to improve the health of the American people.

But you have heard some other things which are fictional. There are other accusations that you have heard or seen on television. You have read in some newspapers and magazines articles to the effect that the American Medical Association and the doctors of America are always against everything, that we are never for anything, and we are *always* against things. Oh, they quote many things.

They quote a statement which came from a former Congressman's speech in 1950 which states the American Medical Association opposed Social Security, which it did not. That the American Medical Association opposed Blue Cross and it did not. And you heard many other similar statements that we have always opposed progressive legislation, or welfare legislation for the good of the people. Nothing could be farther from the truth.

What We Are Against

Are we against things? Why yes, we are against many things. We're against pain and suffering, we're against cancer, we're against polio, we're against unnecessary accidents, we're against anything which will interfere with the enjoyment of life, but in so doing we are for everything which will prolong life, prolong the appreciation and enjoyment of life. We are for the early innocutation of children against diseases so that they will live long and enjoy life.

We are for regular examination and the early detection of diseases not only heart disease, diabetes, nephritis, high blood pressure and the rest, but the early detection of cancer because we know by early detection we can bring into being the marvelous advances of the past few years, to control this disease which today is killing so many of our people. It is the No. 1 cause of death in women, the No. 2 cause of death in men and we know that as we educate the American people as we educate our physicians, as we keep up with the advances in medicine and surgery, we will ever prolong the lives of the American people.

We are for the Salk vaccine and the Sabin vaccine against polio. I am happy to report that in my home City of Miami, in the County of Dade, approximating 1,000,000 people, about three months ago we had an interesting article in the newspaper. As a result of a campaign with the full cooperation of physicians, the Board of Health, our educators, our newspapers, our radio and every other communication medium, we had a long and wide-spread program to innoculate our people with Salk vaccine and later we had the Sabin vaccine because we were one of those in a trial area. Three months ago the results were reported in our newspapers and we had gone 365 days, one solid year, without one new case of polio.

Oh, we're against a lot of things, but because we are against things we are for other things. We are for research. We're for the ever increasing knowledge and research so necessary for the better control of disease.

Oh, but people say that medicine costs so much. I had a young lady from the Cincinnati Inquirer shake her finger at my nose and say, "Doctor Annis, the reason you doctors are going to become socialized is because medicine costs so much." And then she said, "Why does it cost so much?" I told her "Because the American people want jet age medicine. They don't want horse and buggy transportation, they want jet transportation, and the jet that brought me from Miami up North cost $6,000,000 to build. Six million dollars would have bought a lot of horses and buggies, but one jet in one day can move more people from Miami to Chicago, from New York or Cincinnati and back again than a hundred horses and buggies could do in two or three weeks."

We say we live in a marvelous age, and we do. We live in an age of television and color television. We live in an age of direct distance dialing, where I can stay in my office in Miami and call a friend of mine in Sacramento, California, another in Washington, another in New York or Chicago, or probably here in Louisville by merely knowing their phone number, and we can do it direct, and we say this is marvelous, and it is. And it reflects the tremendous advance in the field of electronics and engineering in the past years which has been made available to the American people.

All of you know of the marvelous, the truly marvelous flight of the astronauts from our State down there in Florida at the well-known Cape Canaveral. We were cheered as Americans when these two fine young men, as a result of the multiple research of many people in many fields of endeavor, soared into the heavens and returned safely. But you know, long before the astronauts, we knew that they had missiles down there that they could fire into the South Atlantic 4,000 miles away and hit a target nine times out of ten, not any bigger than the building we are meeting in here tonight.

Oh yes, these marvelous things have been going on. But what I would like to remind you and the American people who are listening tonight is this, that while these marvelous things have been going on in the field of communication, in the telephone industry, in the electronic industry, and the missiles and the astronauts and all the rest, we have had equally marvelous changes in the field of medicine.

Medical Advances

Today we can do things, doctors in small towns and in large towns around America, that would have been considered miracles when I started to practice medicine in 1938. Many of you, through this marvelous medium of television, have seen operations on the heart itself. We have youngsters around this country, and older people, too, with heart defects of various kinds. As you watched on the television cameras you saw there around the table four or five men with many years of training and experience doing the surgery. At the head of the table an anaesthesiologist, with many years of training, bringing the results of the laboratory work which has harnessed the poison that used to be used by natives in killing animals, paralyzing them, the curari and curari derivatives,

and now they have brought it into the operating room to make better surgery possible.

In the background you didn't see the 20, 30 or 40 Americans who gave their own blood, that only the good God himself can make, to make these operations possible because of our blood banks. And over in the background, and I'm sure you didn't see him, there was an industrial engineer, a man who brought the knowledge and the precision of engineering to the operating room so that now we could bypass the heart, oxygenate the blood, keep the brain and other vital structures going, while the surgeons working together opened the heart, corrected the defect and gave a youngster or someone a little bit older, 10, 20, 30 or 40 years that they wouldn't have had.

Progress Taken For Granted

We say it is marvelous and it is. Those of us who do these things and see these things almost daily, have gotten so used to these marvelous advances, that we take them in stride, just as we take the advance of automobiles, new jet airplanes and all of the rest in stride. But in so doing, we have been so busy trying to keep up with the progress of science that sometimes we haven't reminded the American people that though we now have jet-age medicine, it costs a whole lot of mony to bring it to them.

And so the young lady in Cincinnati said, "Well, it's true, we know we have made these great advances and I saw one of those operations on television and I think it is marvelous, but why do hospitals cost so much?" I told her that that same afternoon I had visited in Christ Hospital in Cincinnati, and I visited in a room that was about half the size of the room we are meeting in tonight, and this room—this one room—cost $50,000 to build. Why? Because it housed a 2,000,000 volt x-ray machine and had to be made safe for the rest of the hospital and the people who work there and the patients who were housed and treated there. And there was a patient under treatment at the time that I was there. I looked through a little window—and it wasn't very big, about a third the size of this rostrum—and the window through which I could see what was going on cost $5,000.

But what was going on in the room that was so costly? The treatment was going to give that patient with lymphoma 5, 10, 15 or maybe 20 years more of pleasurable living than she would have had were it not for this expensive room and one 2,000,000 volt x-ray machine that cost $160,000.

But you know, even at Christ Hospital, the greatest single cost is labor. The cost of the people who work there. It takes a lot of people working to run a hospital today. Across this land 70% is the average cost of labor in our hospitals and I am not talking about the doctors. I'm not talking about the equipment, or the drugs, or the other things, but the cost of those people necessary to bring to the American people the products of jet-age medicine.

"Oh," then the young lady said, "I realize that there are many people necessary, but we have heard a lot about the cost of drugs. What about this?"

Well, I told her that not long before we had a gentleman who had started an investigation of the drug industry, a gentleman with a coonskin cap. He was visiting down our way, and you know it is an interesting observation but whenever there is an investigation going on, they always find a reason to investigate it in Miami in the wintertime.

During the course of this investigation, one of my good friends from Washington visited in Miami and he said, "Ed, this is an example of what I am talking about. This is why you fellows are going to get socialized medicine if you don't change it. Here's a capsule, cost me 50 cents in Miami and it only costs 20 cents in South America." And I said, well George, what you said is approximately correct and you know how the story goes: A fellow met an old friend one day and he said Why, Hello Joe, I haven't seen you in ages. I heard you made a million in oil. And he replied, Why Harry, it's good to see you again and what you say is approximately correct except you see, it wasn't me it was my brother, it wasn't oil it was steel, and he didn't make it, he lost it.

But it is approximately correct. Disraeli, many years ago on the floor of the House of Commons, made the statement "It is easier to be critical than to be correct." And, in the interest of truth, let us look a little further into the story of the drug industry, as is seen by a doctor who went into the practice of medicine before we had today's marvelous drugs. May I remind you that in 1936 and 1937 people in this country were dying of pneumonia and others were ill, and we would wait 5, 6 and 7 days for a crisis. Some of them developed empyema and didn't get back to work for 2, 3, 4, 5 or 6 weeks after this illness if they survived, and many a breadwinner was on his back when he should have been out, and wished he had been out working for his family.

Cost of Drugs

One of our great pharmaceutical industries had spent many years and finally had culminated the results of these many years of research, costing $25,000,000 dollars to solve the problem. They built a brand new plant which was going to produce multiple serums against the various kinds of pneumonia, and they were already going into production. Those of us in the practice of medicine were looking forward, we knew about it, we knew it was coming, and we thought, now we can save lives.

But you know what happened? A competitor in America, another research institution also doing resulfanilamide, sulfamerazine, sulfadiazine, sulfasuxidine, sulfathaladine and all the rest of these sulfas idine, sulfathaladine and all the rest of these sulfas came along and we didn't need these serums because sulfa could do it better, could do it quicker, could do it cheaper and could control it even better. And so this $25,000,000 worth of research was no longer necessary. Was it wasted? Oh no, because many of the ideas developed helped us in other fields of endeavor. I merely cite as an example of where some of the money goes which we spend when we buy these drugs.

And there is another drug that came on the American market. When it came, we saw beautiful pictures in our colored magazines which told how it was going to mean a great deal to untold thousands of Americans, and people around the world, because it would restore cripples so they could walk again, it

would allow housewives to do work that they couldn't do, to enable men to continue to work where they couldn't in the past, and this marvelous drug was then made available and the initial cost was very expensive. A day's supply, $200 or $300, and yet without any force of government, without any control of anybody else but the free competition in a great American industry, within a few months the price went from hundreds down to $50.00, then $40.00 and then $10.00 and today you can get for $1.50, or $2.00, a day the results of this same remarkable drug because of competition. Marvelous drugs made available to the American people.

But then this friend of mine said, "Yes, but that's still no reason why I have to pay 50 cents for what I can buy down there for 20 cents." And his question is a good one, but then I reminded him that I was talking about America where this research is done, where the greatest single amount of all the world's medical research put together is performed. I told him that in America we are paying for the research of the past and the present and the future.

We Are "Good Neighbors"

But we are a nation of kind hearts and gentle people. We have been asked to be "good neighbors." Our pharmaceutical industry has been a good neighbor and has gone to other nations and has said, here, here is the formula that we developed in America, the American people developed this because they gave us the money with which to do it. Now, you take this formula and reproduce it; and you save the lives of your people.

In many instances, we built subsidiary companies in those countries, but when we produced the capsules, in those other countries, we did it with the wages paid in those countries, not the wages paid in this country. And if today we want to pay the wages of workers from the raw material to the finished product that are paid in some of these countries, we too can produce these same capsules for 20 cents instead of 50 cents, especially if we want to stop research now and in the future and cut off the $200,000,000 a year spent by private research in this country.

This is the rest of the story that should be told when we point a finger because of the occasional shortcomings which are inherent in human nature that may involve one or another individual in any company. But there is another factor to be considered, not only the price of research and the price of their production, because I am sure that no laboring man or woman, or no labor leader would recommend that we lower the cost of medical care by lowering the wages we pay to those who work in our hospitals, or by lowering the wages that we pay to those who work in producing these marvelous drugs in the drug industry. But there is another factor that we should never overlook when we talk about these marvelous drugs.

I came home a couple of months ago and I hadn't been home but about 10 minutes when the phone rang. A pediatrician was on the other end of the line and she said, "Doctor Annis, I have a little girl, seven years of age, and I think she has a ruptured appendix." I went out to the hospital to operate on the little girl. The mother met me at the hospital. She was a little bit embarrassed and said, "You know Doctor, we don't have quite as many as you do, but we have six. I'm sure that Mary became sick yesterday because her brothers and sisters told me so, but the message just got to me tonight."

Sure enough, the youngster had a ruptured appendix. We operated on her and took out her appendix and put some of these marvelous drugs in her peritoneal cavity, some more in her veins for a couple of days, then gave her some by mouth for a few days more and she went home on the seventh or eighth postoperative day, a well little girl.

How much did it cost? Oh, I don't know, I guess maybe the drugs might have been $30, $40, maybe $50. How much were they worth?

There are many of you in this listening audience, I know, who can remember loved ones who died of this dread disease and I know that many of you will have a personal interest in this true story just as I have, because my father died of a ruptured appendix in the days before the miracle drugs.

The pharmaceutical industry didn't call them miracle drugs, the doctors didn't call them miracle drugs, they were called miracle drugs by the American people who saw people live that used to die, and they saw people now quickly relieved and quickly recovered from infections and diseases which in the past either took some of their loved ones or caused prolonged illness. When we think in terms of how much these things cost, let's be honest and remember just a few years back when we didn't have them, and say yes, they cost a lot, but let's not forget how much they are worth.

The Whole Story

I'm one of those doctors who started in the practice of medicine before the days of sulfanilamide and the antibiotics and I am one of those that is pleased to know that we can do things today in surgery we couldn't do 10, 12 or 15 years ago because of these marvelous drugs. I can tell you, too, that we have drugs today that are prolonging the lives of people with cancer 4, 5, 6, 8 and 10 years. I don't mean just to keep them around and living, I am talking about keeping them around so they can enjoy life and their family and their children, and continue to work. This is a tremendous contribution to medicine as we know it in this country and when someone points a finger of scorn, derision and criticism, let us be honest with ourselves and with the American people and tell them the whole story. This we should do in justice to a great industry. This we should do in justice to truth.

(To be continued in the February Journal.)

EDITORIALS

Physician Recruitment

DURING the past fifteen years there has been an increasing awareness of a physician shortage throughout the United States. This problem was not generally admitted at first, but with the rapidly increasing population and the greater need for more physicians in every phase of medical activity, the demand has become more and more apparent to all concerned. In 1951 when the planning stage for the new medical school in Lexington first got under way, there was considerable doubt in our state and throughout the country that we were greatly in need of increasing the number of medical graduates. Since that time, however, it has become apparent to everyone that our supply is falling far short of the demand even for the present time, and may be critical within a few years.

During this period eleven new medical schools have been established in the United States and many of the long established schools have considerably increased the size of their entering classes. At present eleven of our fifty states are without medical schools. Three of these have already been committed to the establishment of new schools and four others are in process of establishment in states having already one or more schools. There are therefore in the process of establishment now seven new schools in addition to the eleven already built since the war. Four of these being planned are two-year schools. That is very fortunate because a source of supply of students for the third and fourth years will now be available to take the places of those who fail to pass the first two years of examinations. The actual output of graduate physicians should therefore be much better stabilized with the addition of these two-year schools.

The question has naturally arisen and looms large in the minds of some, from whence will come a sufficient number of qualified applicants to supply the increased number of billets now being provided? The most logical answer to this question is in the very rapid increase in college students throughout the country. Every college is being encouraged to increase its capacity for students. Junior colleges are being expanded to four-year schools. New colleges are being built by states and by church and civic groups every year, and still it is claimed that there is a greater and greater demand for facilities to provide our youth with college education. With this increased number of college graduates, the source of supply for medical students is bound to increase proportionately. It appears that the facilities for increasing the number of college students are being provided more rapidly in proportion than are the facilities for increased numbers of medical students.

Not until very recent years has there been any effort on the part of the medical profession or medical schools to actually recruit students. This is now being undertaken with considerable energy, but the other graduate schools, particularly engineering, are far ahead of us in their recruitment program.

The number of college students entering upon their studies with an avowed plan to prepare for medical education has always been large. The pre-medical courses are generally more difficult than others and during the four years of college the pre-medical groups or clubs deminish rapidly in numbers. This has been due in part to the difficulty in maintaining satisfac-

tory grades, to the attractiveness of other specialized forms of education which often require less effort, and to loss of motivation as the pre-medical student progresses through his college years.

Not until recently has there been any real effort on the part of physicians or medical schools to keep in contact with these pre-medical clubs, to direct and encourage the students in their efforts to maintain adequate grades. For the first time in a generation we can assure them that upon completion of their college course, if their standing in scholarship is up to standard and they are otherwise acceptable, there will be a place for them in a freshman medical class without delay. Medical school deans and admission committees are very correctly giving an increased amount of attention to this selected group of candidates.

To the physician not engaged in medical teaching it often seems that the casualty percentage in the freshman and sophomore years of medical schools is remarkably high. One wonders why this should be so when such care is given to the selection of suitable candidates and the elimination of so large a number of applicants who are deemed unsuited. Not only has the medical student who failed in his freshman or sophomore year suffered a severe emotional and economic loss, but with the present lack of supply of two-year medical schools the place which he should have filled during the four years remains vacant and the actual number of graduates so sorely needed is greatly reduced. It does seem that serious attention should be given by faculties of the pre-clinical years in medicine to reduce this casualty of the freshman and sophomore students to a minimum.

Throughout the entire period of education—pre-medical, medical, and post-graduate training years,—the financial problem looms large in the mind of most students. Many capable and worthy high school students do not aspire to the study of medicine simply because they see no possible way of meeting the financial obligations required thereby. The recruitment of medical candidates, therefore, may well begin during the high school years, and where the deterring factor is financial some guidance and help in encouraging that man to enter medicine should be given. Scholarships in colleges are reasonably plentiful for deserving, though poor, candidates. Efforts to obtain an adequate scholarship or supplement his earnings through college could profitably be undertaken by physicians or medical agencies.

Physicians have undeservedly been accused of not lending sufficient moral or financial support to young men aspiring to enter their profession. A thoroughly unfounded charge has occasionally been voiced that physicians desire and encourage a smaller number of medical students in order to make the profession more attractive financially. This charge is absurd and ridiculous. In recent years physicians in every state and in almost every community have made substantial contributions to the construction of new medical school facilities or to the enlargement or improvement of those schools already in operation. These appeals come often through the alumni associations of the schools and are receiving a more universal and a more substantial response than ever before. The American Medical Education Foundation was established in 1951 and the American Medical Research Foundation in 1957. The contributions to these foundations have in a large per cent been made by practicing physicians and have helped very substantially in the distribution of funds to every medical school in the United States from year to year without restriction as to their use, in the improvement of medical education. A considerable number, though not enough, Kentucky physicians have contributed in amounts usually of $100 a year to this fund since its establishment. The contribution is tax deductible and may be designated for the school of the donor's choice.

Physicians have not been remiss in the establishment of scholarships either on a loan or a gift basis. The rural scholarship fund, in operation for about fifteen years in Kentucky, has benefited 223 medical students and has supplied a substantial number of physicians, usually for rural areas. Other scholarships by individuals and institutions are now being established. Recently the Jefferson County Medical Society, through its Medical Foundation, has promised three merit scholarships in order to attract to the University of Louisville School of Medicine students of exceptionally high scholastic standing in competition with other schools which are in better position to offer such inducement. Every dollar to provide these scholarships comes from the pockets of Jefferson County doctors. This is an activity which must be enlarged if we are to compete fairly with other American Medical Schools for the

most desirable candidates.

It should be stated however that the highest grades are not regarded as the most important criterion for a medical student. Grades must be up to a reasonable standard, of course, but any student of better than average scholastic record, good motivation and a willingness to apply himself diligently should survive the rigorous test of medical school. With character and integrity he should become an effective addition to our profession. One must not necessarily be "a brain" to become a good physician.

It has long been impractical and unrealistic to expect the student to go through college and medical school with the severe and ever increasing financial strain and then expect him to continue through a period of intern and residency training without fair and reasonable compensation for his services. The present trend with private hospitals to offer financial inducements to medical graduates for their year of internship is all to the good. Such a change in policy of hospitals is long overdue. Even after the recent graduate has completed his junior internship and desires residency training in some speciality which seems attractive to him, he must continue for three to five years still at completely inadequate compensation. The very ample funds now being provided for research may induce some residents to continue for a year or more of research activity in a subspeciality but are not available for the residency years.

The puny compensation offered interns by teaching or University Hospitals cannot long compete with the resaonably adequate financial support for themselves and their enlarging families offered by private hospitals. It would seem realistic, therefore, that this highly competitive field for junior interns be left largely to the private hospital so sorely in need of his service and, which can find some source for an adequate remuneration to him even if it does slightly increase the cost of medical care for the patients in the hospital. Teaching institutions may more profitably devote their program to residency training. With fewer men they should be able to offer a salary for their years of residency which is in some part commensurate with the service that they render to the hospital. Many teaching institutions have already abandoned the junior internship program in favor of a more adequate residency program, and this seems to make sense.

Perhaps a large percentage of those who look to medicine as a profession do so because of their acquaintance with and admiration for some one or more physicians of high moral and professional standing. The recruitment of candidates for medicine rests to a large part upon the personal contact of physicians with students in their formative years. We should be aware of this and should, by example and precept, present our profession in a favorable light to those younger men who may aspire to succeed us.

Medicine is a profession of service, not of financial reward. It is very interesting to consider the number of children of ministers, missionaries, teachers and physicians who enter the medical profession. This is probably because they have been brought up in an atmosphere of service to humanity and unconsciously adapt this concept of life.

If the physician is diligent in his work he is fairly well assured of reasonable financial security. He will be able to live well, to enjoy the better things in life, and to provide for his family the best of social standing, education, travel, and culture which the great middle class in America prize so highly. He may occasionally even flourish with an exceptionally fine home, an expensive car, or extended travel; but in the long run, he will not be wealthy unless he happens to be an astute business man in addition to being a good physician. Every year a great many men in Louisville depart this life leaving very substantial estates. During the past thirty five years fewer than half a dozen physicians in this city, however, have left estates of more than $500,000.

We cannot offer the aspirant to our profession great financial reward, social or political preeminence; but we can assure him a life of satisfying service, the respect and honor of his fellow men, an enviable position of preference in his community, and reasonable financial security. Our recruitment of physicians should not fail because these are the rewards which men most desire.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Practical Answers to Critical Questions on the Program for the 1962 KSMA Interim Meeting in Owensboro on Feb. 22

Practical answers to many of the crucial questions facing the profession today will be featured at the 1962 KSMA Interim Meeting at Gabe's Restaurant in Owensboro on Thursday, February 22.

"Since 1962 will be a most critical year for medicine on the legislative scene with the King-Anderson Bill and the Kefauver-Celler Bill on the Congressional agenda, this year's Interim Meeting (formerly the County Society Officers Conference) should be of great interest to Kentucky physicians," according to G. L. Simpson, M.D., Greenville, KSMA president.

Doctor Simpson urged all Kentucky physicians to attend the meeting and called it a "must" for medical leaders and county society officers throughout the state.

Five top notch, nationally known speakers headline the one day program. The morning session will feature Carl R. Ackerman, M.D., New York, N.Y., discussing "How Private Practice Can Survive"; Austin Smith, M.D., Washington, D.C., speaking on "When is a Fact a Fact"; and Wesley W. Hall, M.D., Reno, Nevada, surveying the "Rumblings Along the Potomac."

Luncheon speaker will be Robert P. Varley, Th.D., who will discuss, "Medicine's Mission in a Changing Culture." William R. DeMougeot, Ph.D., will give the final address of the meeting in a challenging and practical address entitled, "Do Doctors Dare Debate?"

Dr. Ackerman

Doctor Ackerman, who was featured in the December issue of The Journal, is head of the nation's largest Blue Shield Plan, the United Medical Service in New York. A graduate of the Columbia University College of Physicians and Surgeons in 1930, he was in private practice until 1960. Doctor Ackerman is vice chairman of the Board of Directors, National Association of Blue Shield Plans and is a past president of the Bronx County Medical Society.

With his background information on Blue Shield, Doctor Ackerman will discuss the importance of Medicine's making its voluntary plans work and the need to demonstrate to the public that the profession is capable of providing the mechanism for reasonably priced voluntary medical care.

Dr. Smith

A former editor of the Journal of the AMA and now president of Pharmaceutical Manufacturers Association, Doctor Smith will give a talk which is calculated to shed light on the facts and statistics overlooked in the newspaper coverage of the drug investigations and should be of interest to every physician.

Doctor Smith graduated from Queens University Faculty of Medicine, Kingston, Ontario, in 1938. A member of the International College of Surgeons, he had been affiliated with the AMA in various capacities for 18 years, serving nine years as editor of the AMA journal.

Dr. Hall

The seriousness of the present legislative picture and what physicians can do about it, will be explored by Wesley Hall, M.D., Reno, Nevada. Doctor Hall, a graduate of Tulane University School of Medicine, New Orleans, in 1930, is a native of Mississippi.

A past president of Aces and Deuces, Doctor Hall as a member of the AMA Board of Trustees is well acquainted with the current problems facing the Association and the profession in the legislative arena.

Dr. Varley

A member of the American Academy of Religion and Mental Health, Doctor Varley has been widely acclaimed as a speaker by groups throughout the country. He is presently rector of St. Peter's Episcopal Church in Salisbury, Md. and has a weekly television program entitled "Give Us This Day."

Doctor Varley has done extensive public speaking and has articles published in the *Current Medical Digest* and the American Medical Association's *Regional Conference Journal on Problems Concerning the Aged.* His talk is calculated to be both inspirational and humorous.

Dr. DeMougeot

Director of debate and forensics and professor of speech at North Texas State College, Dr. DeMougeot, through the years, has gained a wealth of information on the subject of compulsory national health insurance. Thoroughly versed on the "pros" and "cons" of the issue, he wrote his doctoral dissertation in 1959 on "Argumentation in the National Health Insurance Movement."

As a debate coach for ten years, he has tutored teams on the subject of compulsory national health insurance. In 1961 his team had the best record out of 147 schools in 30 states attending a convention of the national forensic fraternity. A graduate of N.Y. U., he holds Masters and Doctors degrees from Cornell.

Program

KSMA 1962 Interim Meeting

Gabe's Restaurant, Owensboro **Thursday, February 22**

MORNING SESSION

Gaithel L. Simpson, M.D., Greenville, president
Kentucky State Medical Association, presiding

9.00 a.m.	**Registration**
9:15 a.m.	**Coffee Call**
9:50 a.m.	**Call to Order,** Dr. Simpson
	Invocation,
	Welcome, William J. Oldham, M.D., Owensboro, president Daviess County Medical Society
	Announcements, Woodford B. Troutman, M.D., Louisville, KSMA secretary
10:05 a.m.	**"How Private Practice Can Survive"**
	Carl R. Ackerman, M.D., director, United Medical Service, Inc., New York, N. Y.
10:35 a.m.	**"When is a Fact a Fact"**
	Austin Smith, M.D., president, Pharmaceutical Manufacturers Association, Washington, D. C.
11:05 a.m.	**Coffee Break**
11:15 a.m.	**"Rumblings Along the Potomac"**
	Wesley W. Hall, M.D., member AMA Board of Trustees, Reno, Nevada
11:40 a.m.	**Discussion**

LUNCHEON SESSION

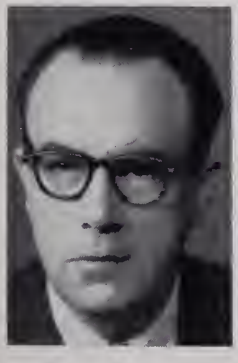
Gaithel Simpson, M.D., presiding

12:30 p.m.	**Invocation,**
1:00 p.m.	**"Medicine's Mission in a Changing Culture"**
	Robert P. Varley, Th.D., Salisbury Parish, Salisbury, Md.

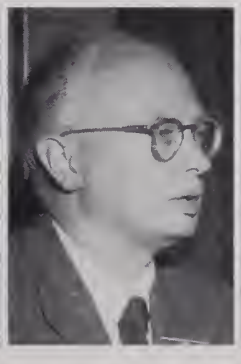
AFTERNOON SESSION

David Cox, M.D., Louisville, KSMA president-elect presiding

1:45 p.m.	**"Do Doctors Dare Debate?"**
	William R. DeMougeot, Ph. D., North Texas State College, Denton, Texas
2.15 p.m.	**Question and Answer Period**
3:00 p.m.	**Adjournment**



Dr. Ackerman



Dr. Smith



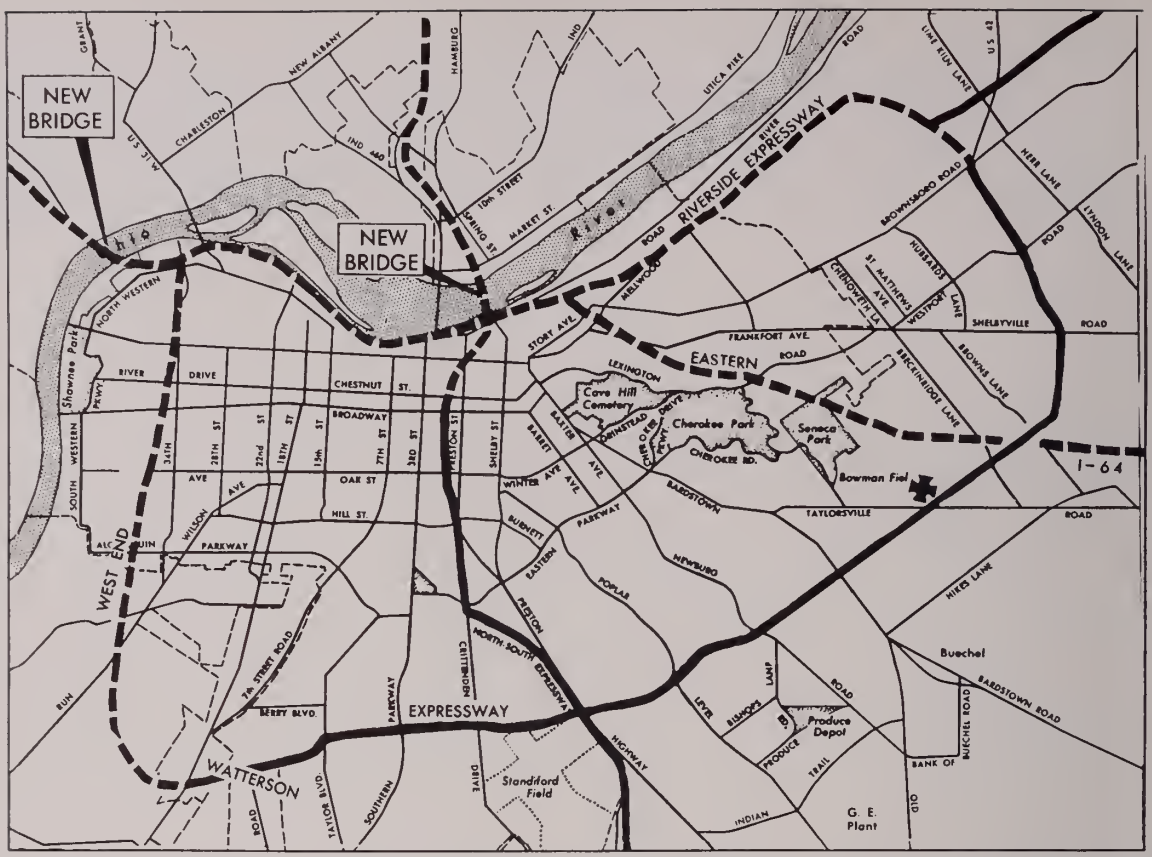
Dr. Varley



Dr. Hall



Dr. De Mougeot



X marks the spot of the location of KSMA's new Headquarters Office Building in Louisville. The new address will be 3532 Janet Avenue and is located in the northwest quadrant of the intersection of the Watterson Expressway and Taylorsville Road.

Headquarters Office Building Ready This Month

KSMA's new Headquarters Office Building, according to George F. Brockman, M.D., Greenville, chairman of the Building Committee, will be ready for occupancy sometime this month. At press time members of the Headquarters Staff were making preparations to move the latter part of the month.

The building is comprised of two wings—the Executive and the Administrative—joined by a glass foyer. The first floor of the building occupies 5,500 square feet and contains 12 rooms on the Administrative side, including offices of the executive and secretarial personnel, the Postgraduate Medical Education Office, the Woman's Auxiliary, and The Journal.

There are three rooms on the Executive side with a Board room covering approximately 950 square feet, an office for the president of the Association, and a small meeting room which employees will also use as a lunch room.

An ample basement of 2,100 square feet contains work and storage space and a fallout shelter. The parking lot will accommodate 20 cars with room for expansion of all facilities when and if necessary.

While Doctor Brockman said that dedication of the building would be on May 20, he extended an invitation to all members to drop by at their convenience and inspect the building.

Reminder Given On Tax Increases

The U. S. Internal Revenue Service reminds employers of increases in the rates of Federal employment taxes which become effective January 1, 1962. The employer tax and the employee tax under the Federal Insurance Contributions Act will each increase from 3 per cent to 3 1/8 per cent. The employer tax under the Federal Unemployment Act will increase from 3.1 per cent to 3.5 per cent.

The social security tax due from self-employed individuals on their income from self-employment will increase from 4.5 per cent to 4.7 per cent for taxable years beginning after December 31, 1961.

Dr. Hammond Joins Health Dept.

Judith S. Hood, M.D., acting director of the Bureau of Maternal and Child Health, announces the appointment of Wylda Hammond, M.D., as director of the Division of Maternal and Child Health, State Department of Health. Doctor Hammond was formerly assistant superintendent of the Children's Division, Sonoma State Hospital, California.

A graduate of the University of California School of Medicine, she was assistant clinical professor of pediatrics there. She comes to Kentucky with her huband, Thomas L. Nelson, M.D., who is with the University of Kentucky Medical Center as associate professor of pediatrics.

Thirtieth Southeastern Surgical Congress Program Is Given

The Thirtieth Annual Meeting of the Southeastern Surgical Congress will be held March 5, 6, 7, and 8, at the Brown Hotel, Louisville. Over 75 speakers will participate in the four-day meeting, including 10 guests.

A special nurses' program is also planned for each of the four days. There will be over 40 participants in this program with many speakers taking part in both programs.

Two combined meetings of surgeons and nurses are planned. The first, on March 5, is a panel on "Pitfalls in Management of Patients With Multiple Injuries," and will include tours and demonstrations. The second will be held March 7 and will be a symposium on "What Are the Advances in Cancer Research Which Have Contributed to the Control of Cancer?" This symposium will also contain tours and demonstrations.

The surgeons' program, with speakers listed as nearly as possible as they will appear in the completed program follows. The completed program will be ready February 15.

MONDAY, MARCH 5

Waltman Walters, M.D., (Guest), Rochester, Minn., "Complicated Lesions of the Biliary Tract and Their Treatment"
Samuel F. Marshall, M.D., (Guest), Boston, Mass., "Choice of Operation for Peptic Ulcer"
Roger E. Wilcox, M.D., Beckley, W. Va., "Subtotal Gastrectomy vs. Antral Resection and Vagectomy"
Guy P. Sharpe, Jr., M.D., Greenwood, Miss., "Trends in Gastric Surgery"
Carl E. Badgley, M.D., (Guest). Ann Arbor, Mich., "Recognition and Treatment of the Irreducible Early Post-natal Congenital Dislocation of the Hip"
Rudolph A. Light, M.D., Oxford University, England, "The Place of the British House Surgeon in the National Health Scheme"
George M. Knauf, M.D., Col USAF, Patrick Air Force Base, Fla., "Medical Aspects of the Mercury Space Program"
Carl E. Badgley, M.D., (Guest), Ann Arbor, Mich., "The Frequent Failure of Recognition of the Lesion and the Need of Early Therapy, Fracture Dislocation of the Hip"
D. Franklin Milam, M.D., Morgantown, W. Va., "Urinary Tract Complications of Pelvic Fractures"
Carl Berg, M.D., Washington, D.C., "Fracture of the Humerus and the Hanging Cast"
Donald J. Davis, M.D., Orlando, Fla., "Traumatic Chest Injuries, Experience in a Community Hospital"
S. Benjamin Fowler, M.D., Nashville, Tenn., "Treatment of the Hand in Rheumatoid Arthritis"
Panel Discussion: "Pitfalls in Management of Patients With Multiple Injuries"
Roger T. Sherman, M.D., Memphis, Tenn., Moderator
Garber Galbraith, M.D., Birmingham, Ala.
Curtis Artz, M.D., Jackson, Miss.
Rudolf J. Noer, M.D., Louisville, Ky.
Carl Berg, M.D., Washington, D. C.
Carl E. Badgley, M.D., Ann Arbor, Mich.

TUESDAY, MARCH 6

Howard C. Taylor, Jr., M.D., (Guest), New York, N. Y., "Special Indications and Comparative Results in Hysterectomy Performed by Various Techniques"
Rowland Zeigler, M.D., Florence, S. C., "Cesarean Hysterectomy"
Discusser: Douglas M. Haynes, M.D., Louisville, Ky.
Abe Mickal, M.D., New Orleans, La., "Carcinoma of the Breast in Pregnancy"
Samuel Karlin, M.D., New Orlean, La., "Intrathoracic Goiters"
Robert G. Chambers, M.D., Baltimore, Md., "Surgical Treatment of Lesions of the Parotid Gland"
Orvar Swenson, M.D., (Guest), Chicago, Ill., "Management of Infants with Jaundice"
Samuel W. Windham, M.D., Dothan, Ala., "Some Facet of Gallbladder Surgery"
John N. Classen, M.D., Baltimore, Md., "Pancreatitis"
Forum on Progress in Surgery, ten papers of ten minutes each, to be announced

WEDNESDAY, MARCH 7

Samuel F. Marshall, M.D., (Guest), Boston, Mass., "Earlier Resection in One Stage for Diverticulitis of Colon"
Felda Hightower, M.D., Winston-Salem, N. C., "Methods of Approach to Low Lying Tumors in the Rectum"
Edgar Boling, M.D., Atlanta, Ga., "Villous Tumor of the Colon and Rectum"
J. Robert Massie, Jr., M.D., Richmond, Va., "Benign Solitary Ulcers of the Colon"
Howard C. Taylor, Jr., M.D., (Guest), New York, N. Y., "The Diagnosis and Treatment of Pelvic Pain of Obscure Origin in Women"
Major F. Fowler, M.D., Atlanta, Ga., "Double Penis: Report of Case With Surgical Management"
Discusser: J. Andrew Bowen, M.D., Louisville, Ky.
J. Garber Galbraith, M.D., Birmingham, Ala., "Newer Concepts in Management of Intracranial Vascular Anomalies"
Wendell B. Thrower, M.D., Charleston, S. C., "Safe Conduct of the Patient Through Cardio-vascular Surgery"
J. Herman Mahaffey, M.D., and Daniel E. Mahaffey, M.D., Louisville, Ky., "Successful Surgical Repair of Abdominal Aortic-Vena Cava Fistula Caused by Rupture of an Arteriosclerotic Aneurysm"
Waltman Walters, M.D., (Guest), Rochester, Minn., "Cancer of the Stomach in the United States and in Certain Oriental Countries"
Rudolf J. Noer, M.D., Louisville, Ky., "Mammary Cancer: The Place of Adjunctive Therapy"
James L. Campbell, M.D., Orlando, Fla., "Ten Years' Experience with Radioactive Gold in Prostatic Cancer"
William S. McCune, M.D., Washington, D. C., "The Surgical Management of Malignant Melanoma"
Symposium: "What are the Advances in Cancer Research Which Have Contributed to the Control of Cancer?"
Murray M. Copeland, M.D., Houston, Texas, Moderator
Stuart M. Sessoms, M.D., Bethesda, Md.—from the internist's point of view
Murray M. Copeland, M.D., Houston, Texas—from the surgeon's point of view
Gilbert H. Fletcher, M.D., Houston, Texas—from the radiotherapists' point of view

THURSDAY, MARCH 8

Orvar Swenson, M.D., (Guest), Chicago, Ill., "The Problems of Intestinal Obstruction in the Newborn"
George Crile, Jr., M.D., (Guest), Cleveland, Ohio, "Rationale and Results of Simplified Treatment of Cancer of the Breast"
Murray M. Copeland, M.D., Houston, Texas, "The Challenge of the Biologic Aspects of Cancer of the Breast"
Owen Gwathmey, M.D., Richmond, Va., "Prevention of Reflux Following Esophageal Resection, "A New Method," Preliminary Report"
James D. Hardy, M.D., Jackson, Miss., "Pulmonary Hemorrhage: Causes and Management"
Jack Wickstrom, M.D., New Orleans, La., "Skeletal Manifestations of the Hematological Diseases"
John A. Brabson, M.D., Charlotte, N. C., Blood Transfusions. Their Reactions, and Particularly the Do's and Don'ts of Giving a Single Transfusion"
George Crile, Jr., M.D., (Guest), Cleveland, Ohio, "Some Biologic Aspects of Cancer With Special Reference to Cancer of the Thyroid"

Nurses' Section

MONDAY, MARCH 5

Willard H. Parsons, M.D., Vicksburg, Miss., "General Preoperative and Postoperative Nursing Care from the Doctor's Viewpoint"
Panel—"Psychological Aspects of Surgery and Surgical Nursing"
Louis Foltz, M.D., Louisville, Ky., psychiatrist
Robert W. Lykins, M.D., Louisville, anesthesiologist
Mrs. Louise Ezell, R.N., staff nurse
Miss Sue Kapfhammer, R.N., operating room nurse
Miss Margaret Keesee, R.N., recovery room nurse
Panel:: "Burns and Electrolyte Balance"
Curtis Artz, M.D., Jackson, Miss., Moderator
M. J. Jurkiewicz, M.D., Gainesville, Fla.
J. D. Martin, Jr., M.D., Atlanta, Ga.
Mr. Melvin Carson, physical therapist, Louisville, Ky.
Miss LaNelle Blackston, R.N., Jackson, Miss.

TUESDAY, MARCH 6

Panel—"Rehabilitation of the Surgical Patient"
Howard Mahorner, M.D., New Orleans, La., Moderator
Francis Massie, M.D., Lexington, Ky.
Carl Berg, M.D., Washington, D. C.
Mrs. Helen Powers, Staff R.N.
Miss Catherine Racque, visiting R.N.
Miss Mary McDonald, Physical Therapist
Panel—"Unusual Occurrences in Operating Rooms"
Mrs. Frances Ginsberg, R.N., Boston, Mass., Guest Speaker
Donald S. Daniel, M.D., Richmond, Va.
Discussers: Harry Lee Claud, M.D., Washington, D. C.
J. Duffy Hancock, M.D., Louisville, Ky.
E. H. Baker, M.D., Louisville, Ky.
Miss Helen I. Harder, R.N.
Sr. Agnes Regina, R.N.
Mrs. Justine Bradley, R.N.
Miss Colleen Call, R.N.

WEDNESDAY, MARCH 7

Panel—"Nursing in Emergencies"
Benjamin Byrd, M.D., Nashville, Tenn., Moderator, "Management of Emergency Rooms"
Amos Koontz, M.D., Baltimore, Md., "Management of Mass Casualties"
Miss Yosita Murakami, R.N.
Miss Curtsinger, R.N.

(Continued on Page 109)

Prescription For Monopoly

THE sponsors of the Kefauver-Celler Bill (S. 1552, H.R. 6245) allege that it will encourage competition in the prescription drug industry. In point of fact, however, its restrictive provisions are likely to force many small companies out of business. The bill, strangely enough, is actually a prescription for monopoly.

The bill makes it more difficult for a small company to obtain a patent.

It often happens that a new chemical compound is discovered almost simultaneously by two different companies, and neither knows which one will eventually obtain the patent. Today, the two firms usually settle the question of priority by negotiation, agreeing beforehand that both will be left free to sell the compound, one as owner of the patent and the other as licensee. This voluntary settlement of patent difficulties is forbidden under the bill, which in effect compels the two firms to fight every case by an interference action in the Patent Office, a costly and time-consuming procedure.

Proponents of the bill have said that this provision will "restore free competition in drug patents" and benefit small manufacturers. Actually, far from helping small companies, this provision will particularly discriminate against them. Fighting every patent interference to the bitter end will be hard on everybody; but the larger companies, with larger financial resources, can weather it better than the small.

The bill makes it difficult for small manufacturers to market valuable new products.

Under present law, newly discovered modifications and combinations of older drugs are patentable if they can be shown to posses useful therapeutic properties. Under the proposed law, however, no patent may be granted on them unless the Secretary of Health, Education, and Welfare has determined that they are not only effective, but actually more effective than any similar product.

Such determination of comparative efficacy by the government is impractical; comparative efficacy must be judged by the experience of the medical profession. Aside from this, however, the provision would hit hardest at small manufacturers. The large companies could perhaps afford the time and expense needed to obtain the additional data required by this provision, but small firms could not, and might well be forced out of research altogether.

The bill severely weakens all drug patents although—like patents in other fields—they provide an indispensable protection to the small manufacturer.

The bill limits the protection of pharmaceutical patents to at most three years (the present limit is 17 years), after which the owner of the patent must license, at a royalty fixed by the government, "any qualified applicant," to make and sell the patented drug. In addition, he must give such applicant, foreign as well as domestic, complete technical "know-how"

This impairment of patents strikes the small manufacturer with particular force. If a small manufacturer discovers and patents a valuable new product, he must license his largest competitors to make and sell it. Fighting against their nation-wide sales force and promotion, he has scarcely a chance of recouping his research investment.

The bill makes a subtle attack on trademarks, although trademarks are the manufacturer's pledge of quality and stimulate competition between companies.

In an effort to minimize the value of trademarks, the Kefauver-Celler Bill provides that the official generic name of all drugs must appear in type as large and prominent as the trademark name.

This attack on trademark names particularly hurts the small research-minded manufacturer. A comparatively unknown firm developing a new drug is tremendously handicapped if its identifying trademark is submerged.

The bill is of concern not only to members of the pharmaceutical industry, but indeed to all industry. In the name of competition, it attacks some of the major methods by which competition is stimulated. Its effect will be to entrench the larger firms and make it harder for the small, research-minded firms to survive and prosper.

John C. Quertermous, M.D.





BULK IS BASIC

in treating constipation of pregnancy

METAMUCIL®

corrects constipation without irritation

"Pregnancy and menstruation[1] are contraindications to the use of the stronger cathartics, since the hyperemia may lead to abortion or excessive menstrual flow."

Metamucil, with its soft, mucilloid bulk, mixes with the intestinal contents and exerts gentle pressure on the intestinal musculature to stimulate normal peristalsis.

In pregnant patients, this natural stimulus strengthens the response of the musculature, reinforces the defecatory reflex in the rectum and, in all but rare instances, resort to colonic irritants becomes unnecessary.

Together with proper dietary management and attention to regularity, mild encouragement to regular evacuation which nearly all pregnant patients require is possible with nonhabit-forming Metamucil.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces, and as lemon-flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

1. Sollmann, T.: A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology, ed. 8, Philadelphia, W. B. Saunders Company, 1957, p. 206.

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Research in the Service of Medicine

Postgraduate Office Revenue Ruled Tax Exempt

On November 29, 1961, the Bureau of Internal Revenue ruled that the Kentucky Postgraduate Medical Education Fund, source of revenue for the KSMA Postgraduate Office, is exempt from Federal Income Tax. It was ruled further, that contributions, bequests, gifts and grants made to us are tax deductible by the donor. This action completed approximately 1½ years of negotiation between the Postgraduate Office, E. Gaines Davis, KSMA legal counsel, and the Bureau of Internal Revenue. The Postgraduate Office is very grateful to Mr. Davis for his efforts.

This means that the KSMA Postgraduate Office can now accept money in the above categories to be used to increase it's activities. With this governmental ruling as a basis, efforts will be made to supplement our funds through applications to various foundations and organizations who have money available for this type of work. Our progress will be reported on this page.

Kentucky Activities

JANUARY

18 **KAGP Northern Kentucky Seminar, Cincinnati, Ohio.**

18 **Cancer Teaching Program, "Oxiodative Enzymes in Proliferating Tissues," University of Kentucky Medical Center, Lexington, Ky.**

24-25 **Postgraduate Course, "ENDOCRINE DISORDERS," University of Kentucky Medical Center, Lexington, Ky.**

FEBRUARY

22 **Lymphomas, University of Kentucky Medical Center, Lexington, Ky.**

22 *KSMA Interim Meeting, Gabe's Restaurant, Owensboro, Ky.*

MARCH

5-7 Southeastern Surgical Congress, Louisville.

16-17 Kentucky Chapter, American College of Surgeons, Lexington.

20-22 Kentucky Hospital Association, Louisville.

22 Kentucky Industrial Medical Association, Louisville.

28-29 Jefferson County Chapter, American Heart Association, Louisville.

APRIL

10-12 Kentucky Public Health Association, Louisville.

10-May 29, **Postgraduate Course, PEDIATRICS, Louisville Children's Hospital, Tuesday mornings, Louisville.**

18-20 Kentucky Tuberculosis Association Annual Meeting, Louisville.

19 Kentucky Pediatric Society Meeting, Frankfort.

25 Kentucky Psychiatric Association Semi-Annual Meeting, Lexington.

Surrounding States

JANUARY

10 Postgraduate course, "Recent Advances in Physical Diagnosis," Indiana University School of Medicine, Indianapolis, Indiana.

18 Postgraduate course, Orthopaedic Treatment for the Office Patient, Vanderbilt University, Nashville, Tennessee.

28-Feb. 1, Academy of Orthopaedic Surgeons, Chicago, Illinois.

FEBRUARY

7 Postgraduate course, Treatment of Arteriosclerotic Diseases, Indiana University School of Medicine, Indianapolis, Indiana.

7-10 American College of Radiology, Roosevelt Hotel, New York.

8 Postgraduate course, Selected Problems in Infectious Disease, Vanderbilt University, Nashville, Tennessee.

8 Postgraduate course, Pulmonary Emphysema, Indiana University School of Medicine, Indianapolis, Ind.

14-17 Mid-South Postgraduate Medical Assembly, Memphis, Tennessee.

MARCH

1 Postgraduate course, Management of the Psychiatric Patient in Daily Practice, Vanderbilt University, Nashville, Tennessee.

2-3 Postgraduate course, Selected Topics in Internal Medicine, University of Virginia, Charlottesville, Virginia.

5-6 Postgraduate course, Ophthalmology, Ohio State University, Columbus, Ohio.

5-7 American College of Surgeons Sectional, Sheraton Cadillac, Detroit, Michigan.

7-8 Indiana Academy of General Practice, French Lick, Indiana.

18-21 Missouri State Medical Association, St. Louis, Missouri.

22 Postgraduate course, Common Pediatric Surgical Problems, Vanderbilt University, Nashville, Tennessee.

22-24 Central Surgical Association, Cincinnati, Ohio.

26-28 American College of Surgeons, Memphis, Tennessee.

APRIL

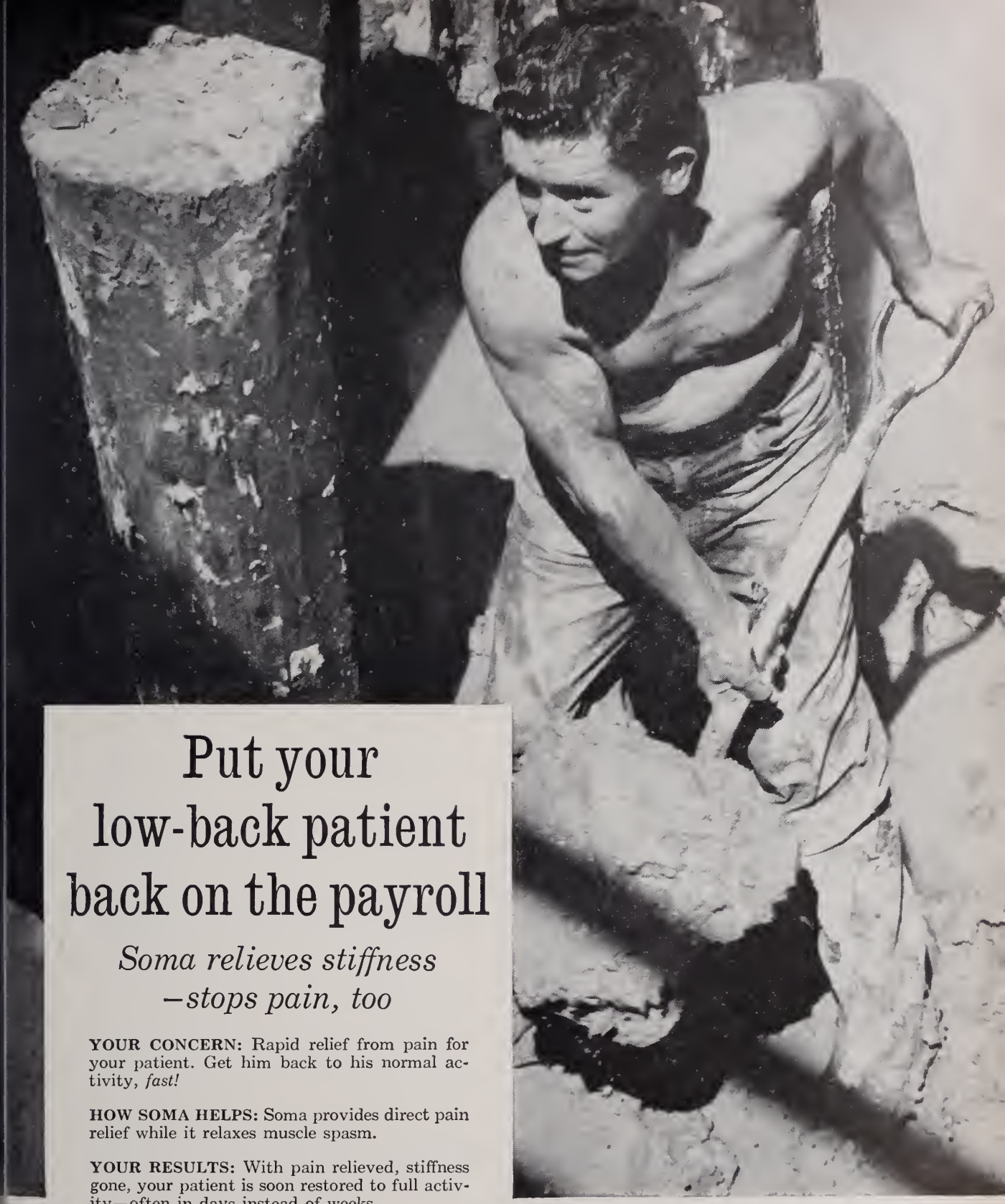
5-7 Postgraduate course, Electrocardiography, University of Virginia School of Medicine, Charlottesville, Virginia.

9-13 American College of Physicians, Philadelphia.

16-18 American Association for Thoracic Surgery, St. Louis, Missouri.

23-28 American Academy of Neurology, New York, New York.

George F. Harris, M.D., has announced the closing of his office in Warsaw on November 15. Doctor Harris, who has practiced in Warsaw since 1954, is joining William K. Haney, M.D., at the Hilltop Medical Center, Madison, Ind.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. **172**:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

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Robert J. Hoffman, M.D., South Fort Mitchell, chairman of the Campbell-Kenton County Medical Society's Awards Committee, presents W. Vinson Pierce, M. D., Covington, with the Society's Distinguished Service Award for meritorious service. At left is George H. Riley, M.D., Erlanger, immediate past president, and at right is Morris M. Garrett, M.D., Covington, new president for 1962. Not shown is Donald K. Dudderar, M.D., Newport, re-elected secretary of the group who took part in setting up the meeting.

Doctor Pierce Honored By Campbell-Kenton Society

W. Vinson Pierce, M.D., Covington, was given the Distinguished Service Award for Meritorious Service from the Campbell-Kenton County Medical Society at the Society's annual dinner meeting on December 16.

Doctor Pierce, who has been active for many years in local, state, and national medical organizations, received numerous telegrams from medical organizations across the nation. Included were messages from the following: the American Medical Association, the Kentucky State Medical Association, American Urological Association, Southern Medical Association, the staff of Blue Cross-Blue Shield, the Board of Directors of Kentucky Physicians Mutual, Kentucky Surgical Society, Kentucky Chapter of the American College of Surgeons, and a Resolution from the Board of Trustees of the KSMA.

The Board of Trustees Resolution called attention to the many organizations which Doctor Pierce has served at one time or another and called attention to his devoted efforts to improve the lot of his patients through working with organized medicine. The resolution also commended the Campbell-Kenton County Society on recognizing Doctor Pierce in this manner.

New officers elected by the Society during the meeting were: Morris M. Garrett, M.D., Covington; Wilbur Houston, M.D., Covington, president-elect; Donald Frickman, M.D., Newport, vice president; and Donald K. Dudderar, M.D., Newport, secretary-treasurer.

113 Attend Fourth Annual Norton Seminar

The fourth annual Norton Memorial Infirmary Postgraduate Medical Seminar was held December 14 at the Infirmary in Louisville. Co-sponsored by the Kentucky Chapter of the American Academy of General Practice, the program was approved for six hours of Category I credit.

A total registration of 113 included 96 physicians from Kentucky (51 from Jefferson County) and 17 from southern Indiana.

Kenton D. Leatherman, M.D., was chairman of the morning session, and Edgar B. Morgan, M.D., presided during the afternoon. Sixteen speakers participated in the day-long program.

Members of Norton's postgraduate education committee are: Robert Lich, Jr., M.D., chairman; William A. Blodgett, M.D., co-chairman; Robert C. Long, M.D., and David Nelson, M.D.

NOTE

To County Society Secretaries and Members

Annual AMA dues will be increased $10 on January 1, 1962, and an additional $10 on January 1, 1963, following action by the AMA House of Delegates in New York, June 26. When this increase becomes effective, the annual dues for active members will be $35 a year in 1962 and $45 in 1963. This is the first AMA dues increase in 12 years.

Carl Noble, M.D., has opened offices in Beattyville which were formerly occupied by **J. M. Smith, M.D.,** who has moved to Memphis, Tenn. Doctor Noble, a 1955 graduate of the University of Louisville School of Medicine, has been practicing medicine and surgery in Dayton, Ohio.

AMA's 15th Clinical Meeting Attended By 2,500 M.D.'s

A scientific program consisting of lectures, symposia, panel discussions, breakfast roundtables, exhibits, motion pictures, and closed circuit color televiion attracted over 2,500 physicians to the AMA's 15th Clinical Meeting. The meeting was held November 26-30 in Denver where it was last held in 1952.

Topic highlights of the scientific program were: the effect of American habits on health; the influence of heredity on disease; the impact of space research on general medicine; medical computers and electronics; the virus and disease; care of the skin; eyeglasses and contact lenses; suicide; its cause and prevention, and radiation accidents.

Jonas E. Salk, M.D., Pittsburg, originator of the killed virus polio vaccine, appeared on a half-day program devoted to the virus.

The six special color television programs were projected life-size on a 9 by 12 foot screen. Several of the programs presented live surgery with a special hookup allowing a panel discussion of the procedure in the Auditorium. The Smith, Kline and French Color TV Unit, now in its 13th year of televising scientific programs at medical meetings, handled the programs.

The Third National Conference on Medical Aspects of Sports was held during the Clinical Meeting and a special one-hour television show on "Sports Medicine" was also given over Denver's station KLZ-TV. A KSMA member, Owen B. Murphy, M.D., team physician at the University of Kentucky, took part in the program to explain conditioning for such sports as golf, bowling, and tennis.

The AMA's policy-making House of Delegates held sessions during the meeting. Kentucky was represented at these sessions by George P. Archer, M.D., Prestonsburg; George F. Brockman, M.D., Greenville, and Robert C. Long, M.D., Louisville. Their report on the House of Delegates meeting appears on page—.

At the opening session of the House of Delegates, it was announced that contributions totaling $435,275.93 had been received by the American Medical Education Foundation from physicians in six states. The contributions were: Utah, $12,030; New Jersey, $31,072.12; Illinois, $185,000; Indiana, $36,590; California, $167,237.50, and Vermont, $3,346.31.

These contributions brought the total given to medical schools this year by physician members of the 50 state medical societies to $1,072,951.27.

Those attending the AMA meeting from Kentucky were:

George Archer, M.D., Prestonsburg
Thomas H. Biggs, M.D., London
George F. Brockman, M.D., Greenville
David M. Cox, M.D., Louisville
R. E. Davis, M.D., Central City
George E. Dodson, M.D., Madisonville
Richard F. Greathouse, M.D., Louisville
Horace Harrison, M.D., Owensboro
Jorge O. Limjoco, M.D., Harlan
Robert C. Long, M.D., Louisville
Thomas N. MacKrell, M.D., Louisville
Paul F. Maddox, M.D., Campton
Owen B. Murphy, M.D., Lexington
J. Vernon Pace, M.D., Paducah
John C. Quertermous, Jr., M.D., Murray
Gaithel L. Simpson, M.D., Greenville
William R. Willard, M.D., Lexington

Doctor Long Chairs AMA Reference Committee

Robert C. Long, M.D., Louisville, one of KSMA's three delegates to the AMA, chaired the highly important reference committee on reports of the Board of Trustees at the recent Interim Meeting of the House of Delegates of the AMA, November 26-30.

Reports handled by this reference committee were of such importance and magnitude that hearings lasted the entire day of Tuesday, December 27.

Among some of the more important matters handled by the reference committee were: reports of the Commission on Cost of Medical Care and American Political Action Committee (AMPAC); work of the scientific sections; a special report of the Committee on Communications and a number of resolutions.

KSMA Delegates Attend AMA House Sessions

Representing KSMA in the AMA House of Delegates at the Interim Meeting at Denver, November 26-30, were Robert C. Long, M.D., Louisville, who in the absence of W. Vinson Pierce, M.D., senior delegate from Covington, served as chairman of the Kentucky delegation; George F. Brockman, M.D., Greenville, and George P. Archer, M.D., Prestonsburg, who served as Doctor Pierce's alternate.

Gaithel L. Simpson, M.D., Greenville, KSMA president; and David M. Cox, M.D., Louisville, KSMA president-elect; alternate delegates J. Vernon Pace, M.D., Paducah, and John C. Quertermous, M.D., Murray, and other members of KSMA and staff attended the House meetings.

Doctor Pierce, who was unable to attend the Denver meeting because of illness in the family of his associate, William R. Miner, M.D., Covington, has resigned his post as delegate and this would have been his last meeting as a KSMA delegate and as chairman of the Kentucky delegation. During the session, the Kentucky delegates called him to express their feelings at his inability to attend.

At the close of the Denver meeting, Doctor Long expressed Doctor Pierce's regrets on not being at the meeting and explained that this was the final session at which Doctor Pierce would have served. He also commented on KSMA's appreciation for his many years of fine service in its behalf.

Doctor Long also expressed the Association's gratitude for the services of Doctor Brockman who is retiring with this session as a delegate from Kentucky.

William J. Colburn, M.D., has been elected mayor of Calvert City. He has practiced medicine in Calvert City since 1953, shortly after his graduation from the U. of L. School of Medicine. He has been medical examiner and physician for the city's chemical complex, and has served on the city council for the past two years.

Health Care, AMPAC, Polio Vaccine Studied By AMA House of Delegates at Denver

Among the more pressing problems considered by the House of Delegates of the American Medical Association at its 15th Clinical Meeting in Denver, November 26-30, were: 1. social security health care, 2. relations with the American College of Surgeons, 3. organization of the American Political Action Committee, 4. medical discipline, and 5. polio vaccine.

The House heard Leonard W. Larson, M.D., AMA president from Bismarck, North Dakota, sound the keynote for the Association's campaign to oppose enactment of King-Anderson legislation in 1962. He told the House that proposals to incorporate health care under social security system would "certainly represent the first major irreversible step toward the complete socialization of medical care."

The compelling issue, Doctor Larson declared, is socialization versus voluntarism—or compulsion versus freedom of choice. He predicted that courage, determination and the will to win on the part of physicians will bring the defeat of the King-Anderson bill in Congress next year.

Pointing out that "we are engaged in an historic struggle to preserve our country's unique system of medical care and our stature as a profession," Doctor Larson said:

"We are *for* voluntarism. We do not believe that Americans, acting either as citizens or as patients, require central direction from government in their choice of doctor or hospital, in the spending of their health care dollars, or in their selection of the health services and facilities best suited to their own individual needs."

The House of Delegates gave enthusiastic approval to Doctor Larson's address and took several actions reaffirming strong support for the Kerr-Mills program to aid the needy and near-needy aged, and urging a concerted, determined fight against Social Security health care proposals in Congress.

The House strongly urged all state and county medical societies to recognize the impending threat and to prepare now for any eventuality by continuing to oppose any scheme which tries to impose a substandard system of medical care on the American people.

"United, as well as individual, effort is essential," the House declared. "To stop short of our total effort is to invite disaster and to let loose upon our beloved America irreversible forces which will ultimately destroy her. We cannot and we must not fail."

The House agreed with the intent of five resolutions which expressed strong dissatisfaction over recent statements by a spokesman for the American College of Surgeons, and it also approved a Board of Trustees report informing the House that arrangements have been made for a January meeting with the ACS Board of Regents to discuss that organization's recent statements and policy positions. The report expressed hope that the meeting "will lead to a unification of effort in behalf of American medicine."

The House instructed the Board of Trustees to take the five resolutions to the January meeting and to report to the delegates as soon as possible on the results of the meeting. In taking the action, the House approved a reference committee report which said:

"Your reference committee believes the public airing of disagreements between large segments of medicine can only confuse and shake the confidence of the public in the medical profession and distort the true image of medicine which the American people should have.

"However, in its hearing upon the several resolutions relating to the recent statements of the American College of Surgeons, all those who testified were in opposition to the actions and statements of the ACS. The majority of those who spoke were Fellows of the American College of Surgeons."

The House heartily approved the purposes and goals of the recently-organized American Medical Political Action Committee and urged all physicians, their wives and interested friends to join AMPAC and other political action committees in their states and communities.

The purposes of AMPAC, which is an organization separate and distinct from the American Medical Association as required by federal law are:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.

2. To encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records and positions of parties, officeholders and candidates for elective office.

3. To assist physicians and others in organizing themselves for more effective political action and for carrying out their civic responsibilities.

4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

The House received from the Council on Constitution and Bylaws a proposed amendment which would have made it possible to implement a recommendation by the Medical Disciplinary Committee that was approved by the House at the June, 1961, meeting. This recommendation was to change the bylaws so as to confer original jurisdiction on the Association to suspend and/or revoke the AMA membership of a physician found guilty of violating the Principles of Medical Ethics or the ethical policies of the Association, regardless of whether or not action has been taken against him at the local level. However, after considerable discussion on the floor of the House, the proposed amendment was referred back to the Council on Constitution and Bylaws.

The House adopted a resolution which urged that medical societies at the local, county, district or state levels throughout the United States should encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures for poliomyelitis.

The resolution stated that on the basis of the results

of the surveys, the local medical society should determine the type of vaccine and the most effective type of program which will be of greatest benefit to the public.

Until such time as all three types or oral vaccine are available, the resolution concluded, the Salk vaccine should be the vaccine of choice for routine poliomyelitis immunization, with the choice of program for administering the vaccine to be determined on a local basis by each county medical society.

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Disapproved of two proposals which would have required that *resolutions* be introduced 30 and 45 days, respectively, before Association meetings.

Approved a statement that physicians have an *ethical obligation* to participate in medical society activities and express their opinions fully and freely.

Commended those constituent medical societies which have moved forward in the area of *human relations* by eliminating membership restrictions based on race or color. In connection with the same subject, Doctor Peter Murray of New York City, retiring after 12 years of service in the House, told the delegates in a farewell address that Negro physicians now have some kind of medical society membership in every state except one.

Approved a recommendation that a special House committee be appointed to investigate all facets of the operation of the *Joint Commission on Accrediation of Hospitals.*

Approved the combining of the American Medical Education Foundation and the American Medical Research Foundation into the *American Medical Association Education and Research Foundation,* effective next January 1.

Reaffirmed the previous policy that physicians should have the privilege of prescribing drugs by either generic or brand name.

Approved the principle of *income tax deductions* for medical care of the aged.

Endorsed the administration of indigent medical care programs developed in cooperation with local medical organizations as a legitimate activity of state and local health departments.

Urged the elimination of all "categories" in programs of *assistance to the needy* at the federal and state level, with all assistance provided through a single program.

Urged more vigorous promotion of voluntary nonprofit prepayment health plans.

Urged every physician in the United States to use automobile *seat belts.*

Recommended as a civil defense measure, a *mass immunization* program for the general public.

Final registration at the meeting reached a total of 6,138, including 2,976 physicians.

Robert C. Long, M.D., Louisville
KSMA Delegate to the AMA

W. B. Hilbun, M.D., opened his office for the practice of medicine in Jamestown on November 13. He had practiced in the county previously, and has finished a two-year tour of duty with the U.S. Force.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

February 27, 28, March 1 and 2, 1962

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics — **Teaching Demonstrations**

Medical Color Telecasts — **Instructional Courses**

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1962 Annual Meeting — Kentucky State Medical Association

Columbia Auditorium — **Louisville, Kentucky** — **September 18, 19, 20**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman

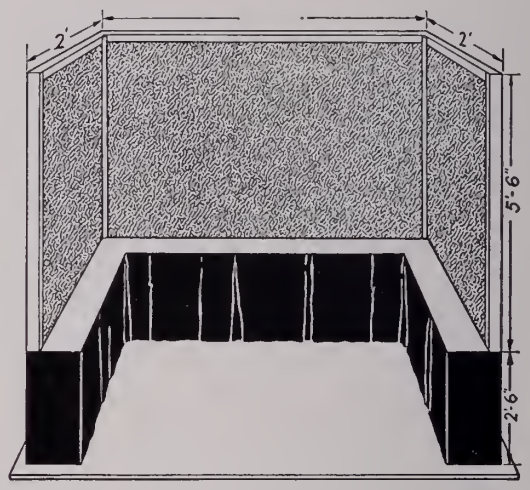
Committee on Scientific Exhibits

Heyburn Building,

Louisville 2, Kentucky

Applications for space should be received before July 1, 1962

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

U. of L. Medical Library Lists New Services

Several new services are being made available by the Kornhauser Memorial Medical Library of the University of Louisville School of Medicine. According to Eugene Conner, M.D., chairman of the Medical Library Committee of the U. of L. and the Jefferson County Medical Society, these services include:

The new Xerox 914 photocopier which reproduces any kind of article on any kind of paper;

Over 900 different journals in the medical sciences —including many new titles and back issues;

Eight parking spaces for visitors using library facilities.

In addition, plans are under way for a $1,000,000 library building and land has been allocated for it in the developing medical center.

The Fund which began with Doctor Kornhauser is being revived in order to help continue essential services. Doctor Kornhauser's three classes of donors will also be continued. They are: $100 for Patrons; $25 for Fellows; and $10 for Sustaining. All donations are tax deductible.

Dr. Horine Gives 1,000 Acre Estate To Boy Scouts

Emmet Field Horine, M.D., KSMA's official historian, is donating his 1,000-acre farm and estate at Brooks, Ky., to the Old Kentucky Home Council of Boy Scouts for a camping site and game refuge.



Dr. Horine

Doctor Horine, one of Kentucky's first and now a retired heart specialist and longtime conservation enthusiast, bought the first section of the estate —5¾ acres—in 1919. He has added to it from time to time since then, the largest single addition being 475 acres. In 1954 he turned all the fields into a tree-planting project. Since he has owned the farm, he has planted between 90,000 and 100,000 trees, mostly pine, poplar and walnut.

The entire property has also been a game refuge, supervised by the state, for some time. Doctor and Mrs. Horine specified that the reservation be continued as a bird-and-animal refuge and that the forestry operations also be continued.

The property will be known as the Helen and Emmet F. Horine Reservation and will also be used "for the promotion of the ability of boys to be useful citizens, to train them in Scoutcraft, and to teach them patriotism, courage, tolerance (both locally and worldwide), self-reliance, and kindred virtues."

The Scouts will eventually use the reservation for overnight camping. The main house will probably be used as a training center for adult Scout leaders. Title to about five acres, including the Horine home and other buildings valued at $45,000, will be transferred immediately. Another six parcels of the property will be acquired by the Scouts over the next four years. The Horines will continue to live on the property.

Kentuckians To Participate In College of Surgeons Program

The American College of Surgeons will hold the third of four 1962 sectional meetings in Memphis, Tenn., March 26-28. More than 400 doctors are expected to attend. All members of the medical profession are invited.

Four KSMA members will participate in panel discussions during the meeting. They are: Rudolf J. Noer, M.D., F.A.C.S., Louisville; Ben Eiseman, M.D., F.A.C.S., Lexington; Laman A. Gray, M.D., F.A.C.S., Louisville; and Francis M. Massie, M.D., F.A.C.S., Lexington.

Subjects they will discuss are: "Gastrointestinal Bleeding of Unknown Etiology," Doctor Noer; "Management of Surgical Patients on Steroids, Anticoagulants and Antibiotics," Doctor Eiseman; "Congenital Anomalies of the Lower Urogenital Tract and Gastrointestinal Tract," Doctor Gray; and "Neoplasms of the Breast," Doctor Massie.

The Breathitt County Medical Society was the first to make a membership report for the 1962 associational year to the KSMA Headquarters Office.

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Digest of the Minutes of the KSMA Board of Trustees

The first regular meeting of the KSMA Board of Trustees for the 1961-62 Associational year was a day-long session held Thursday, October 19 at the Brown Hotel in Louisville. Among the more important actions of the Board were:

1. Full support of the Kentucky Rural Health Conference to be held at Kentucky Dam Village on November 2.

2. Authorization of the headquarters office to urge county societies to accept the AMA recommendation and have one meeting a year on the activities of the Joint Commission for the Accredication of Hospitals.

3. Heard a report by John D. Gordinier, M.D., mediocolegal administrator.

4. Listened to a detailed report of the Building Committee by George Brockman, M.D., Greenville, its chairman. Following his report, arrangements for the securing of necessary capital to finish the new building were approved. Authorization was also made for forming a memorials commission and also for the inclusion of a fallout shelter in the building. The Board accepted the recommendation of the Building Committee that not more than $20,000 be spent in furnishing the new building, taking care of landscaping and other final details.

5. Authorized the Bylaws Committee to study the matter of district grievance committees, along with the operation of the Professional Relations Committee.

6. Heard the request of a representative of the Christian Science Committee on Publication for Kentucky to exclude members of the Christian Science denomination from the proposed KSMA immunization bill, to be introduced in the 1962 Legislature.

7. Heard a proposal for KSMA to launch an educational campaign on cult activity in Kentucky, by professional public relations consultant.

8. Heard the report of the Executive Committee on nominations for personnel for KSMA councils, committees and special representatives and approved the report.

9. Appointed the KSMA legislative congressional district key men, following recommendations from the Executive Committee.

10. Voted to express appreciation to Edmund Pellegrino, M.D., professor and chairman of the department of medicine at the University of Kentucky College of Medicine for his work as symposium editor for The Journal of KSMA for the past two years.

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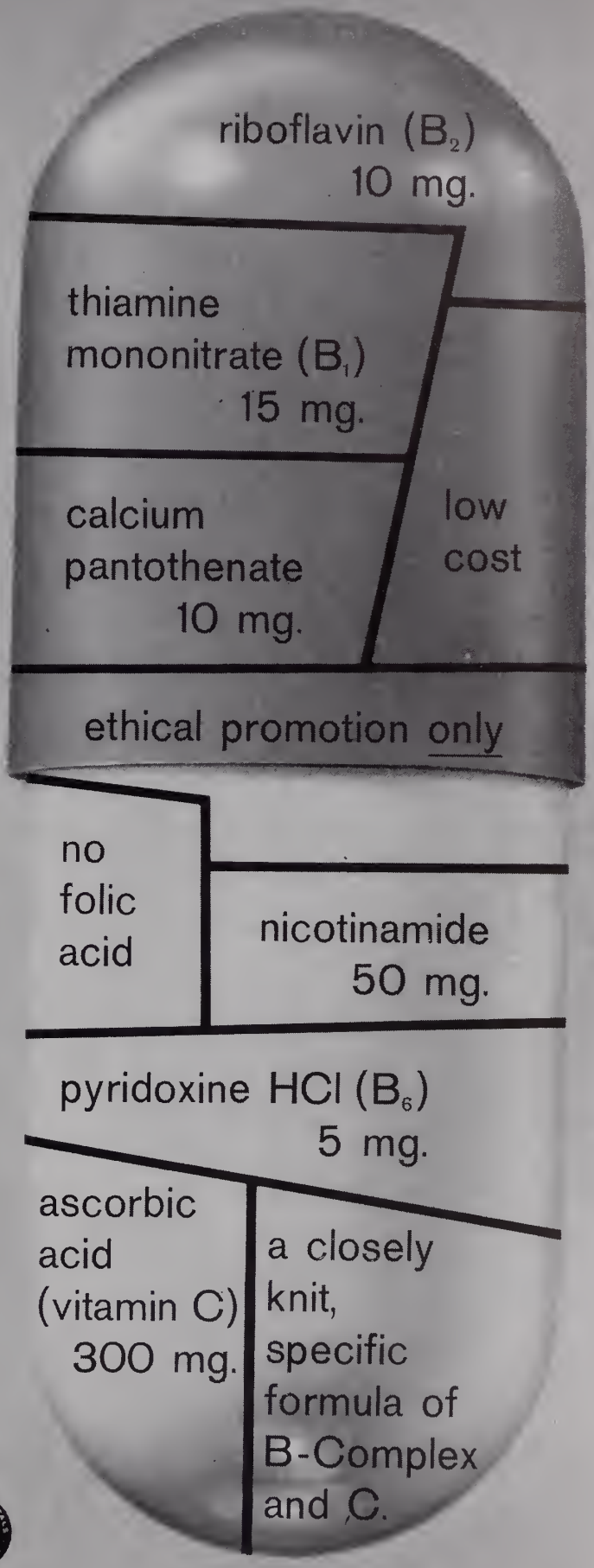
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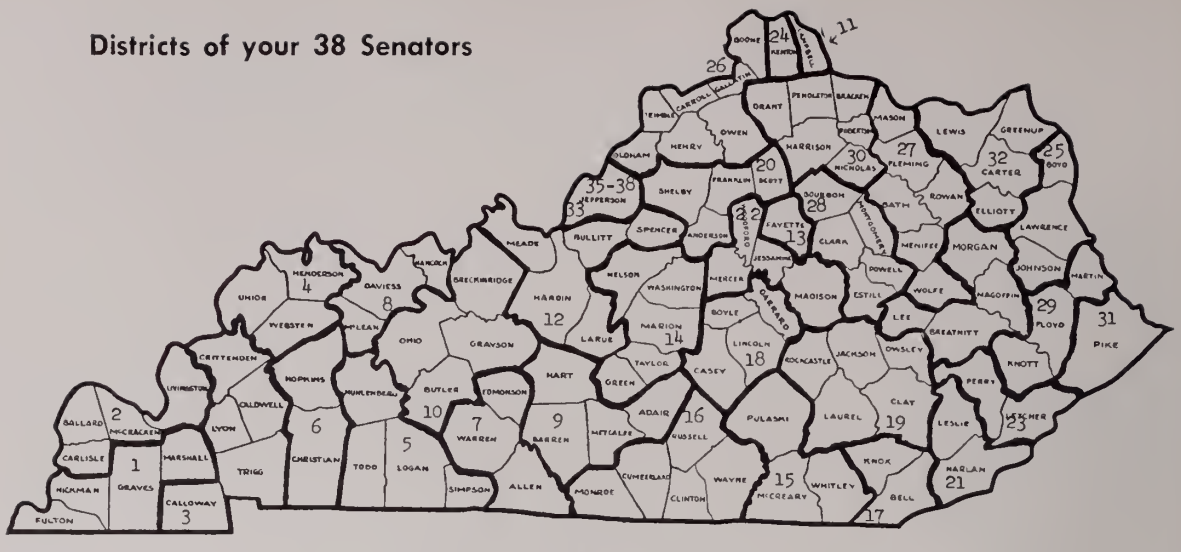
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Districts of your 38 Senators



Number denotes Kentucky Senatorial District.

Senators and Representatives Listed For 1962 Session

Kentucky's 138 senators and representatives will convene in Frankfort on January 2, and will meet for approximately 60 days. New laws will be passed and many of the present laws will be altered. At the last session 833 bills were introduced in the House and Senate and 103 of this number had medical implication. Forty-six of the 103 bills passed

In order to assist you with information on your 1962 legislators, again the Journal is printing a list of their names, addresses and districts with maps showing the counties they serve.

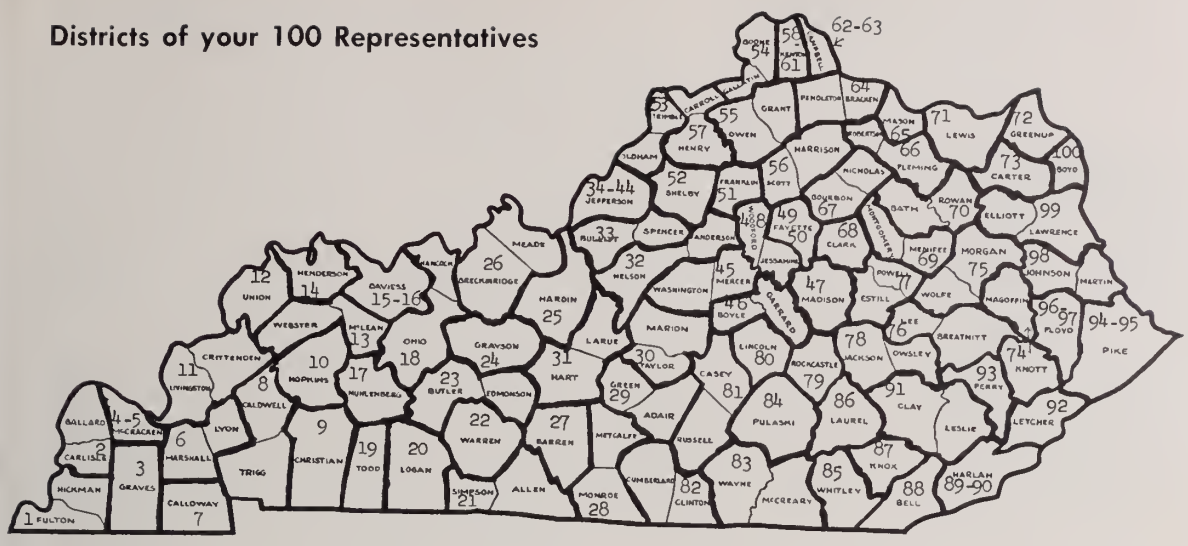
Kentucky General Assembly 1962 Members of Senate

District	Home County	Senators
1	Graves	George Brand-D, Mayfield
2	McCracken	Tom Garrett-D, Paducah
3	Calloway	George E. Overbey-D, Murray
4	Webster	J. Murray Blue-D, Providence
5	Logan	Everett White-D, Russellville
6	Hopkins	Frederick E. Nichols-D, Madisonville
7	Warren	Rex A. Logan-D, Smith's Grove
8	Daviess	Casper Gardner-D, Owensboro
9	Barren	Richard L. Garnett-D, Glasgow
10	Breckinridge	Paul L. Fuqua-R, Hardinsburg
11	Campbell	Lambert Hehl, Jr.-D, Fort Thomas
12	Bullitt	J. D. Buckman, Jr.-D, Shepherdsville
13	Fayette	Shelby C. Kinkead-D, Lexington
14	Marion	Broadus E. Hickerson-D, Lebanon
15	McCreary	O. O. Duncan-R, Whitley City
16	Cumberland	Dr. William C. Mann-R, Marrowbone
17	Bell	Durham W. Howard-R, Pineville
18	Garrard	John W. Swope-R, Harrodsburg
19	Clay	Fred F. Bishop-R, Teges
20	Anderson	Marvin Edwards-D, Lawrenceburg
21	Harlan	H. Nick Johnson-R, Harlan
22	Jessamine	Spencer Cobb-D, Nicholasville
23	Letcher	Archie Craft-D, Whitesburg
24	Kenton	James C. Ware-D, South Fort Mitchell
25	Boyd	George D. Conley-D, Ashland
26	Gallatin	Alvin Kidwell-D, Sparta
27	Fleming	Ed J. Kelly-D, Flemingsburg
28	Powell	Herbert T. Derickson, Jr.-D, Stanton
29	Floyd	Burnis T. Martin-D, Prestonsburg
30	Harrison	Wilson Palmer-D, Cynthiana
31	Pike	Tom Raney-D, Pikeville
32	Carter	Bert Kiser-D, Olive Hill
33	Jefferson	Bernard J. Bonn-D, Louisville
34	Breathitt	John Raymond Turner-D, Jackson
35	Jefferson	Martin J. Duffy, Jr.-D, Louisville
36	Jefferson	Scott Miller, Jr.-R, Louisville
37	Jefferson	C. W. A. McCann-D, Louisville
38	Jefferson	Vernon C. McGinty-R, Louisville

Kentucky General Assembly 1962 Representatives

District	Home County	Representatives
1	Fulton	Hoyt Barnett-D, Hickman
2	Ballard	Noah J. Geveden-D, Wickliffe
3	Graves	Lon C. Barton-D, Mayfield
4	McCracken	Julian M. Carroll-D, West Paducah
5	McCracken	Fred Morgan-D, Paducah
6	Marshall	Shelby McCallum-D, Benton
7	Calloway	Charles Lassiter-D, Murray
8	Caldwell	Virgil Smith-D, Princeton
9	Christian	John M. Dixon-D, Oak Grove
10	Hopkins	Richard L. Frymire-D, Madisonville
11	Livingston	George F. Harris-D, Salem
12	Union	James Holloran-D, Sturgis
13	Webster	Milton Ashby-D, Sebree
14	Henderson	Lewis N. Johnson-D, Henderson
15	Daviess	Louise Gasser Kirtley-D, Owensboro
16	Daviess	R. E. Hale-D, Owensboro
17	Muhlenberg	James P. Hahn-D, Greenville
18	Ohio	Wayland Render-R, Centertown
19	Todd	H. A. Hampton-D, Trenton
20	Logan	Paul E. Young-D, Olmstead
21	Simpson	Samuel R. McCracken, Jr.-D, Franklin
22	Warren	A. E. Tucker-D, Bowling Green
23	Edmonson	Walter Browning-R, Brownsville
24	Grayson	Damon Majors-D, Caneyville
25	Hardin	Sam H. Watkins-D, Elizabethtown
26	Breckinridge	A. R. Dyer-D, McQuady
27	Barren	George J. Ellis, Jr.-D, Glasgow
28	Metcalfe	Wallace Bartley-R, Summer Shade
29	Adair	T. M. Watson-R, Knifley
30	Marion	James E. Whitlock-D, Lebanon
31	Hart	Jack D. Bunnell-D, Hardyville
32	Nelson	Sam Houtchens-D, Bloomfield
33	Bullitt	Leo A. Blemmel-D, Shepherdsville
34	Jefferson	Charles E. Gaines-R, Louisville
35	Jefferson	Jesse O. Johnson-R, Louisville

Districts of your 100 Representatives



Number denotes Kentucky Representative District.

36	Jefferson	E. Bruce Blythe, Jr.-R, Louisville
37	Jefferson	Louis E. Ballenger-R, Louisville
38	Jefferson	Clarence R. Miller-D, Louisville
39	Jefferson	John W. Farmer-D, Louisville
40	Jefferson	Fallis Vernon Buky-R, Louisville
41	Jefferson	Frank Wood-R, Louisville
42	Jefferson	Amelia M. Tucker-R, Louisville
43	Jefferson	Elmer L. Leister-R, Louisville
44	Jefferson	Jack Lesshafft-R, Louisville
45	Mercer	Edwin Freeman-D, Harrodsburg
46	Boyle	Howard P. Hunt, Jr.-D, Danville
47	Madison	Willie W. Greene-D, Richmond
48	Woodford	James T. Alexander-D, Versailles
49	Fayette	J. Y. Brown-D, Lexington
50	Fayette	R. P. Moloney-D, Lexington
51	Franklin	Ralph Bates-D, Frankfort
52	Shelby	Luther F. Morgan-D, Shelbyville
53	Trimble	Harry W. Wood-D, Milton
54	Boone	Dan J. Roberts-D, Walton
55	Grant	Franklin Webster-D, Williamstown
56	Harrison	John Swinford-D, Cynthiana
57	Henry	Louis T. Peniston-D, New Castle
58	Kenton	Russell R. Oelsner-D, Covington
59	Kenton	V. O. Cottengim-D, Covington
60	Kenton	John J. Isler-D, Covington
61	Kenton	T. P. Fitzpatrick-D, Covington
62	Campbell	Eugene A. Ostertag-D, Fort Thomas
63	Campbell	James E. Murphy-D, Newport
64	Pendleton	Eugene B. Hancock-D, Falmouth
65	Mason	Mitchell B. Denham, M.D.-D, Maysville
66	Fleming	Herbert F. Fern-D, Ewing
67	Bourbon	Brooks Hinkle-D, Paris
68	Clark	Walker H. Wiseman-D, Winchester
69	Menifee	Otto Ingram-D, Frenchburg
70	Bath	Charles H. Hart-D, Sharpsburg
71	Lewis	Wayne Secrest-R, Vanceburg
72	Greenup	L. H. Nicholls-D, Greenup
73	Carter	H. T. Sparks-D, Olive Hill
74	Knott	Carlos Huff-D, Hindman
75	Wolfe	Carl Lacy-D, Daysboro
76	Breathitt	Thomas B. Howard-D, Jackson
77	Estill	Luther Patrick-R, Irvine
78	Owsley	William Vickers-R, Booneville
79	Rockcastle	Money Ed Cummins-R, Mt. Vernon
80	Lincoln	T. J. Hill, III-D, Stanford
81	Russell	Leonard E. Wilson-R, Jamestown
82	Cumberland	Claude R. Willen-R, Burkesville
83	McCreary	Archie Brown-R, Sterns
84	Pulaski	Leonard Hislope-R, Somerset
85	Whitley	Will K. Peace-R, Williamsburg
86	Laurel	Paul W. Cornett-R, Mershons
87	Knox	Mrs. Frances Jones Mills-D, Gray
88	Bell	Mason Slusher-D, Beverly
89	Harlan	Lawrence Lankford-D, Cawood
90	Harlan	Fielding S. Hensley-R, Wallins
91	Clay	John E. White-R, Manchester
92	Letcher	William Jordan-D, Jenkins
93	Perry	J. D. Smith-D, Dwarf
94	Pike	T. T. Colley-D, Robinson Creek
95	Pike	Gether Irick-D, Stone
96	Floyd	Allen Slone-D, Blue River
97	Floyd	Ben Martin-D, Drift
98	Martin	Albert Dempsey-R, Inez
99	Lawrence	Russell Dobyns-D, Louisa
100	Boyd	Harry King Lowman-D, Ashland

Doctor Haller Named Markle Scholar

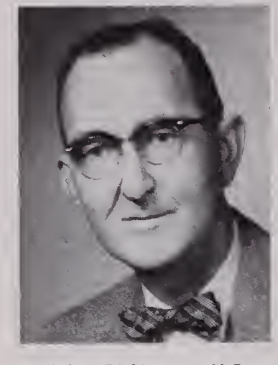
In the 1960-61 report of the Markle Foundation, J. Alex Haller, Jr., M.D., of the University of Louisville School of Medicine, is named as one of 25 Markle Scholars whose appointments began July 1, 1961. Doctor Philip Davidson, president of the U. of L. is also listed on the 19 member Committee which interviewed 56 candidates.

The Markle Foundation was established in 1927 by the late John Markle, Pennsylvania coal operator, "to promote the advancement and diffusion of knowledge . . . and the general good of mankind." During 1960-61, it appropriated $1,220,000 for medical education. $750,000 was allocated to the 25 medical schools where the scholars are located and will teach and conduct research. Two other major grants announced were $200,000 to the University of Rochester School of Medicine and Dentistry for its library and $125,000 to the Association of American Medical Colleges for general support.

Other Markle Scholars in Kentucky between 1948 and 1961 were: Frank Falknew, M.R.C.S., L.R.C.P., 1957; Hubert C. Pirkle, M.D., 1960; Beverly T. Towery, M.D., 1949, and Arthur C. White, M.D., 1959, all of the University of Louisville. The University of Kentucky was represented by Rene B. Menguy, M.D., Ph. D., 1958; George W. Schwert, Jr., Ph. D., 1949; and Frank C. Spencer, M.D., 1956.

Ky. Physicians Mutual Re-elects Officers

The Board of Directors of Kentucky Physicians Mutual—the Blue Shield Plan for Kentucky—met November 16 and re-elected all officers for another one-year term.



John Dickinson, M.D.

The Board is headed by John Dickinson, M.D., Glasgow, president. Other officers are: Richard J. Rust, M.D., Newport, first vice-president, Hubert Jones, M.D., Berea, second vice-president; J. P. Sanford, Louisville, secretary; and Branham B. Baughman, M.D., Frankfort, treasurer.

J. Duffy Hancock, M.D., Louisville, was chairman of the Nominating Committee. In his report to the Board he recommended that the present officers remain in office inasmuch as they have performed their duties with the utmost efficiency.

Doctor Dickinson, who received his medical degree from the University of Louisville in 1933, is a Fellow of the American College of Surgeons, the Southeastern Surgical Congress, and the Kentucky Surgical Society.

Northern Ky. Seminar Scheduled By KAGP

The annual Northern Kentucky Seminar of the Kentucky Academy of General Practice will be held January 18 at the Sheraton Gibson Hotel in Cincinnati. A Cardiovascular Symposium will be featured on the program with Richard D. Kruer, M.D., Southgate, as chairman. James A. Schroer, M.D., Newport, will moderate the morning session and Eugene P. Fromm, M.D., Cincinnati, president of the Southwestern Ohio Society of General Physicians, will moderate the afternoon session.

Participating in the morning session will be: Johnson McGuire, M.D., Cincinnati, who will speak on "Coronary Heart Disease;" John T. Reeves, M.D., Lexington, discussing "Indications for Cardiac Catherization;" and Ralph Shabetai, M.D., Cincinnati, who will talk on "Common Congenital Heart Disease." Gustav Eckstein, M.D., Cincinnati, will be the luncheon speaker.

The following speakers will appear during the afternoon: Alvin B. Ortner, M.D., Louisville, who will discuss, "Peripheral Vascular Surgery;" Noble O. Fowler, M.D., Cincinnati, speaking on "Curable Heart Disease;" J. Alex Haller, Jr., M.D., Louisville, who will present a paper on "Extra Cardiac Congenital Abnormalities;" and Robert A. Helm, M.D., Cincinnati, who will give a talk on "Cardiac Emergencies." The program has been approved for six and one half hours of Category I Credit by the AAGP.

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1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

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Dr. Steigman To Direct National Child Care Study

Alex J. Steigman, M.D., chairman of the department of pediatrics at the University of Louisville School of Medicine, is going to the headquarters of the American Academy of Pediatrics in Evanston, Illinois. He will take a new position there as director of a national research study on the care of children.



Dr. Steigman

The study will be operated under the Joint Committee on Pediatric Practice, Research and Education. The purpose is to ascertain: 1. the status of practice, research and teaching in child health; and 2. the most effective use of medical and paramedical manpower in child care in the community and in research and teaching in universities and institutes.

Four steps are to be covered in the study: 1. a study of the care of children by private and public facilities; 2. a study of the medical facilities, personnel and support for research in child health; 3. a study of present predoctoral and postdoctoral education and training; and 4. an estimate of the needs in each of the areas of practice, research and teaching to meet the future expansion of the child population.

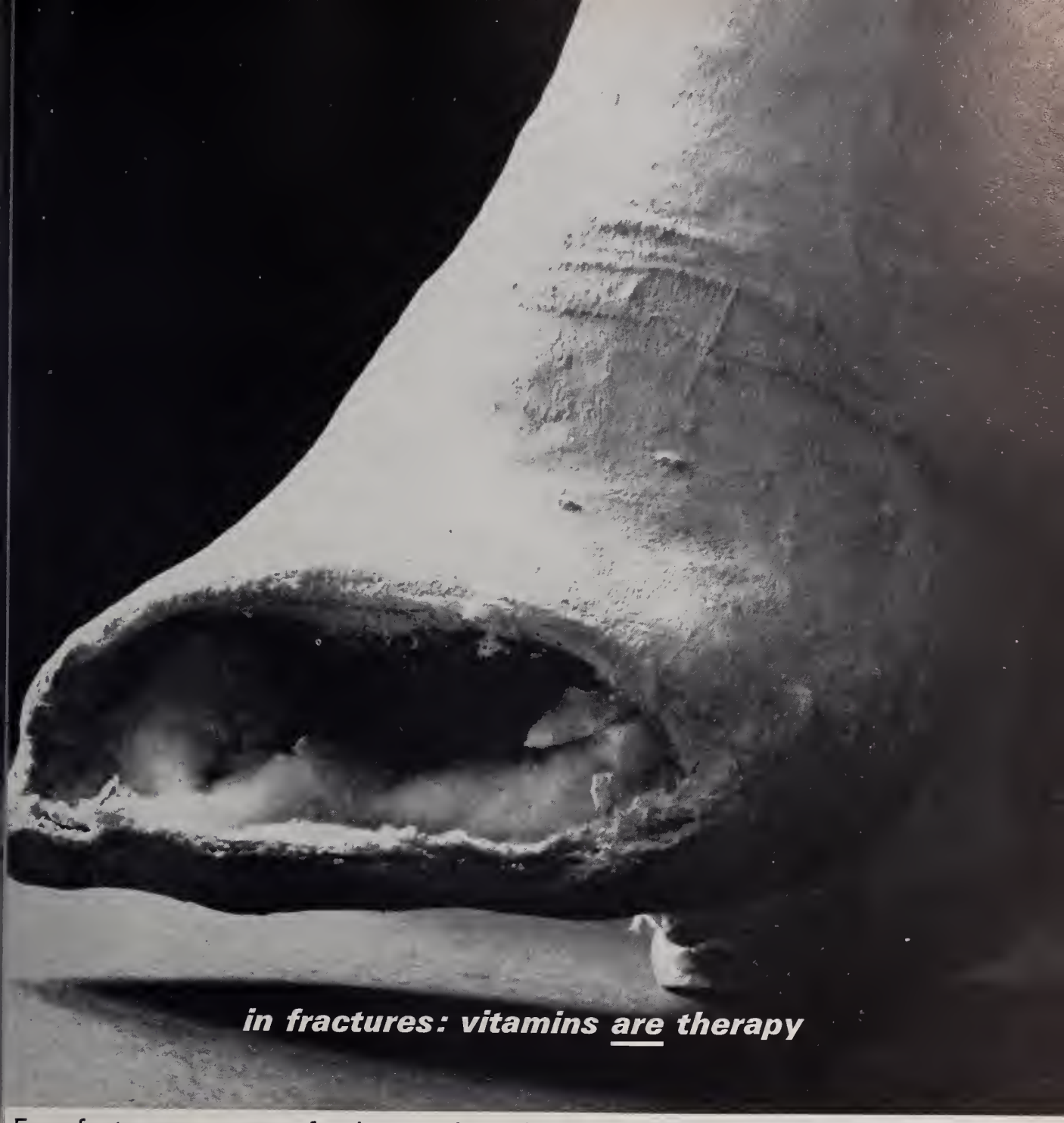
Doctor Steigman, who has been with the U. of L. for the past 11 years, received his M.D. degree from Temple University in 1938. He also holds an honorary Sc. D. degree from that school. He has taught at Temple, Pennsylvania, and Harvard; been National Research Council's Senior Fellow in Pediatrics at the University of Cincinnati, special consultant to the Communicable Disease Center of the Public Health Service, and Expert Civilian Consultant in Pediatrics to the U. S. Army.

He is active in the affairs of the American Academy of Pediatrics; is a member of 15 national scientific societies, author of 91 scientific articles and contributing author to five textbooks. He has directed several research projects at the U. of L., including a study of twins with Frank Falkner, M.D., which made Louisville the headquarters of an international study of growth and development.

Charles H. Mathis, M.D., has begun the general practice of medicine in Russellville in association with **Lycurgus E. Johnson, M.D.,** and **Thomas G. Threlkeld, M.D.** Doctor Mathis, a 1959 graduate of the University of Tennessee School of Medicine, interned at Vanderbilt Hospital and Nashville General Hospital. He served for four years with the U.S. Air Force with the rank of captain.



Anton Refregier, left of Woodstock, New York, stands before his mural in the main lobby of the Medical Sciences Building of the University of Kentucky Medical Center. With him are William R. Willard, M.D., center, vice president of the Medical Center and Dean of the College of Medicine; and Richard B. Freeman, right, chairman of the U. of K. Art Department. The painting is oil on canvas and measures 18½ by 9½ feet. It depicts Man's beginning and his need for the preservation of life, from the unscientific, superstitious ages, through age-old discoveries of the curative powers of Nature and unplanned discoveries to the modern scientific age.



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
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Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
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Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.
Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, a few cases of leukopenia and thrombocytopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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Student AMA

University of Kentucky

Experiments in Education

"When one visits a medical school, he is usually shown research equipment and research in action and although education is the primary function of a medical school, how often do you hear of a session, a symposium, or a meeting which concerns itself with education?" These are the words of Harold W. Brown, M.D., distinguished visiting professor of the Pathology Department at the University of Kentucky College of Medicine. Doctor Brown, professor of Parasitology at the College of Physicians and Surgeons Columbia University, continues, "Seldom is an exciting experiment or technique in education brought out.



Harold W. Brown, M.D.

"In fact, the research attitude of the faculty has become so widely known that students, our employers, enter our laboratories and offices with "I apologize for taking your time" or "I know you are busy," etc. Here, after all, is our real product, a seeking student, our opportunity, our responsibility. If we gave as much thought, effort, time and experimentation to teaching as we do to research, teaching would thrive too."

Doctor Brown's experimental ideas on teaching parasitology began when he was a second year medical student and was, as are most of us, more interested in medicine (human biology) than zoology or parasitology. He coined the term "Parasitic Diseases" to more accurately describe the interests of medical students. "This important group of diseases, when presented as a zoological exercise with emphasis on morphology, bores medical students whose interest is in disease of man, not Laurer's canal and antepygidial bristles. In teaching parasitology to medical students I cast my vote for a delectable taste rather than a nauseating overdose."

In order to compete successfully for the interest of the student, abundance of laboratory material is needed. Doctor Brown came bringing the course he was to teach lock, stock, and barrel. He brought a 20-year collection of some 3,000 slides which are considered by many to be the best in the world, also his complete set of gross specimens, lantern slides, films, and literature. The course consisted of 56 hours of instruction and differed from the one at Columbia only in that six weeks of more concentrated instruction was given at U. of K. in comparison to 12 weeks of less concentrated study at Columbia. This was a ready-made experiment in education for Doctor Brown and a challenge to U. of K. medical students to compete with those at Columbia. The identical practical and lecture tests were given and the only conclusion that may be drawn is that there was no statistical difference between the scores from the two schools.

With a full length color movie, Doctor Brown introduced the U. K. medical students to another interesting experiment in medical education entitled "Medicine in the Tropics." This elective at Columbia is a joint program administered by the medical school and the Aluminum Company of America. Through this program a number of medical students spend two months of their fourth year in such places as Surinam and Liberia. "Medicine in the Tropics" expresses interest not only in the diseases more or less peculiar to the tropics, but also in the most common diseases of the tropics such as tuberculosis, syphilis, malnutrition, pneumonia, leprosy, dysentery, and the host of diseases which have a world-wide distribution but which, due to climate, economics and race are often very prevalent and severe in the tropics.

Doctor Brown also has interests in Kentucky. From 1927-30, while a graduate student at John Hopkins, he worked in cooperation with the Frontier Nursing Service in Eastern Kentucky through a grant from the Rockefeller Foundation to make a survey of parasitic diseases and develop some new antihelminthic drugs.

Doctor Brown's aim has been that of Oliver Wendell Holmes, M.D., professor of anatomy at Harvard some 30 years, who wrote, while a medical student, "My aim has been to qualify myself not for a mere scholar, for a follower after other men's opinions, for a dependent on their authority—but for a character of a man who has seen and therefore knows; who has thought and therefore has arrived at his own conclusions." It was this that Doctor Brown has tried to instill in the Class of 1941 when he said, "You don't have to have superior intelligence to become a doctor, but you do have to be willing to work . . . Do not expect to be taught a great deal; rather hope for a stimulating environment in which you can learn through your own efforts with our help."

James Cunningham, Class of '64
U. of K. Chapter, Student AMA

Who reaches his ideal thereby surpasses it.
—Friedrich Nietzche

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Former Waverly Administrator, S. A. Ruskjer Dies

S. A. Ruskjer, 72, formerly administrator of the now-closed Waverly Hills Tuberculosis Sanatorium, Louisville, died of a heart attack November 24 at his home on the sanatorium grounds. He had been administrator of the sanatorium since 1945.

Before coming to Louisville he was administrator of Mason Memorial Hospital, Murray, and Riverside Hospital in Paducah. Since Waverly Hills closed last July, Ruskjer had been director of hospital administration for the Kentucky-Tennessee Conference of Seventh-Day Adventists. He was also a consultant in hospital administration to the Kentucky State Tuberculosis Hospital Commission and to the Battle Creek, Mich., Health Center and the Madison, Tenn., Hospital and Sanatorium, both Seventh-Day Adventist institutions.

In September he was elected first vice president of the 4,500 member American College of Hospital Administrators.

Dr. Teague Heads Advisory Unit

Russell Teague, M.D., Frankfort, State Health Commissioner, has been named to the committee on public policy and legislation of the American Public Health Association for a three-year term. He will be chairman of the committee which will recommend public-health policy and legislation in the United States.

PGME Records Highest Attendance

The course on "Thermonuclear Disaster" sponsored by KSMA's Postgraduate Medical Education Office and held in Lexington on December 7, had the highest attendance of any postgraduate course held so far in Kentucky. One hundred twenty-four physicians, nurses, Civil Defense representatives and interested lay people were present. This program was supported by M.E.N.D., and featured an entire faculty of out-of-state speakers.

New Orleans Assembly Planned

The 25th annual meeting of the New Orleans Graduate Medical Assembly will be held March 12-15, 1962, at the Roosevelt Hotel. Carroll L. Witten, M.D., Louisville, will be one of the guest speakers on the program.

The 18th annual Clinical Tour will follow the Assembly. The tour will cover the Mediterranean from March 16-April 6. For further information, contact Mannie D. Paine, Jr., M.D., Secretary, Room 105, 1430 Tulane Avenue, New Orleans 12, La.

In Memoriam

U. L. Alumni Re-elect Dr. Giannini

J. Thomas Giannini, M.D., Louisville, has been re-elected president of the University of Louisville Medical Alumni.

Other newly elected officers are George Sehlinger, M.D., vice president, and Frederick Smock, Jr., M.D., secretary-treasurer. Both are Louisville physicians.

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Ellis To Direct Indigent Program

Edward E. Ellis, 42, Frankfort, has been appointed director of Kentucky's medical aid to the indigent program for the State Department of Economic Security. He succeeds Caleb Ballard who died in October.

"Ellis will have supervision of all aspects of the medical care program which fall within the jurisdiction of the Department of Economic Security and will be directly responsible to me," Commissioner Earle V. Powell, who made the announcement said.

Dr. Gardner Speaks At Vanderbilt

Hoyt D. Gardner, M.D., Louisville, advisor to the University of Louisville chapter of the Student AMA, was the guest of the Vanderbilt Medical School chapter on December 12. He spoke on current legislative problems facing medicine today.

Doctor and Mrs. Robert H. English, Henderson, have returned from a tour of the Near East. Doctor English attended the international meeting of the Chemotherapy groups in Naples.

Leslie W. Langley, Jr., M.D., has opened an office in Elizabethtown where he will limit his practice to pediatrics. Doctor Langley, a 1953 graduate of the University of Louisville School of Medicine, has had a practice of pediatrics in Somerset for the past five years. He was certified by the American Board of Pediatrics in 1958 and is a Fellow of the American Academy of Pediatrics.

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News Items

A 1946 graduate of the University of Maryland School of Medicine, **Jerome E. Cohn, M.D.,** has joined the Medical Center of the University of Kentucky where he limits his practice to internal medicine. Doctor Cohn interned at the University of Maryland and took residency training at Duke University and Bellevue Hospital, New York. He served with the U.S. Navy Medical Corps from 1943-50 with the rank of lieutenant junior grade.

Robert E. Cornett, M.D., Jackson, has received indefinite deferment from active duty with the U. S. Army and has resumed his practice. Army officials ruled that Doctor Jackson's call to active service would result in a hardship on Breathitt County which would then have only two physicians.

A new member of the Medical Center staff of the University of Kentucky is **Thomas L. Nelson, M.D.,** who will limit his practice to pediatrics and pediatric allergy. Doctor Nelson received his medical degree from the University of California in 1946 and interned at Permanente Foundation Hospital, Oakland. He took residency training at the University of California Hospital, San Francisco and served for two years with the U.S. Army Medical Corps with the rank of captain. He has had previous practices in San Francisco and Eldridge, California.

Irvin S. Rosenbaum, M.D., Louisville, was presented with a special plaque representing Israel's Bar Mitzvah Award. According to **Harold F. Berg, M.D.,** Louisville, chairman of the Louisville State of Israel Bonds Campaign, Doctor Rosenbaum was honored for "devoted and outstanding leadership in promoting the economic development of Israel through the bonds campaign."

Clarence Deweese, M.D., an Ohio County native and a 1906 graduate of the University of Louisville School of Medicine, retired on October 31 after more than half a century of Medical practice. Doctor Deweese began practice in Horse Branch after graduation and moved to Fordsville in 1908. He took graduate training in eye, ear, nose and throat at Tulane University in 1910 and again in 1912. In 1920 he opened an office in Lexington where he practiced until his retirement.

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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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Council, Committee Reports

Council on Legislative Activities

John C. Quertermous, M.D., and
Robert D. Shepard, M.D., co-chairmen

Lexington **November 15, 1961**

The Council on Legislative Activities had its first meeting since the 1961 House of Delegates session on October 25 in Lexington. Recommendation and mandates on legislation by the House were discussed and some plans were made for their implementation. Much of the business on the agenda was referred to the new Council on Legislative Activities members since they will be attending their first meeting scheduled for November 15.

Seven Members are on the Council on Legislative Activities for this coming year. They are:

John C. Quertermous, M.D., Murray, Chairman, National Affairs

Robert D. Shepard, M.D., Lexington, Chairman, State Affairs

B. B. Baughman, M.D., Frankfort

J. Duffy Hancock, M.D., Louisville

Daryl P. Harvey, M.D., Glasgow

Thomas Leonard, M.D., Frankfort

F. R. Scroggin, M.D., Dry Ridge

The old Council consisted of five members. Wyatt Norvell, M.D., and George Archer, M.D., are no longer on the Council since Doctor Norvell is chairman of KSMA's Board of Trustees and Doctor Archer is one of Kentucky's Delegates to the AMA.

On November 15, the Council and the eight Congressional District Legislative Key Men Committee met in Louisville.

John Quertermous, M.D., Murray, chairman of National Legislative Affairs, presided over the portion of the meeting dealing with national affairs. Preserving medicine as a free enterprise and plans for effectively opposing H. R. 4222 received much attention. The Council and Committee endorsed the actions of AMPAC (American Medical Political Action Committee) and also endorsed and asked for immediate implementation of KEMPAC (Kentucky Educational Medical Political Action Committee). The annual Washington Dinner date was set for March 13, 1962. This is the occasion where physicians from congressional districts meet with their legislators in Washington.

Robert D. Shepard, M.D., Lexington, chairman of State Legislative Affairs, presided over the State part of the meeting. The members gave careful thought and study to bills that are being drafted for introduction in the 1962 State Legislative Session. The bills, when developed in final form, will be presented to the KSMA Board of Trustees for final approval. The legislative key men of each county medical society will receive copies of the proposed bills that are finally approved. Keep in touch with your country legislative key man for the latest information.

Council on Communications and Public Service

N. Lewis Bosworth, M.D., Chairman

Blue Cross-Blue Shield Building, Louisville
December 7, 1961

The Council on Communications and Public Service held its first meeting for the associational year Thursday December 7 at the Blue Cross-Blue Shield Building, Louisville.

House of Delegate referrals directed to this council were discussed and directed to the proper committees.

In addition, this council approved several Health Education exhibits for use in 1961-62 and two recommendations dealing with civil defense from the Emergency Medical Service Committee.

This council also considered plans for dedication ceremonies of the new building, methods of promoting health education and safety belts, an indoctrination program for new members and the distribution of a health column.

Reports from the chairmen of the Diabetes, School Health, Rural Health and Senior Day Committees were heard by the Council.

Eleven recommendations concerning programs for the associational year were passed at the meeting.

AMEF Committee

Robert McClendon, M.D., Chairman

Brown Hotel, Louisville **November 30, 1961**

The American Medical Education Foundation Committee met November 30 in the Brown Hotel, Louisville to discuss and plan a program to encourage KSMA members to contribute to Medical Schools.

Suggested methods of promoting the AMEF campaign offered by the committee were agreed upon by the deans of the two medical schools and the president of KSMA.

Jack E. Ryon, AMA field representative was present at the meeting to help plan this year's AMEF program.

Building Committee

George F. Brockman, M.D., Chairman

Louisville **December 14, 1961**

The report of the Building Committee to the Board of Trustees was made by the chairman, George F. Brockman, M.D., Greenville.

Final grading has been done, the lawn has been seeded, all major furnishings have been ordered and landscaping has been contracted.

The KSMA Headquarters Office staff is planning on moving to the new building on January 15, at which time the Administrative Offices should be finished except for painting files to harmonize with the offices. The Executive Offices should be finished shortly thereafter and a meeting of the committee is planned tentatively for January 17 or 18 at the new building.

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Recent bibliography: 1. A.M.A. Council on Drugs, New and Nonofficial Drugs 1961, Philadelphia, Lippincott, 1961, pp. 142-147. **2.** Beckman, H.: The Year Book of Drug Therapy, Chicago, Yr. Bk. Pub., 1961, p. 271. **3.** Eastman, N. J., and Hellman, L. M.: Williams Obstetrics, ed. 12, New York, Appleton-Century-Crofts, 1961, pp. 845-1035. **4.** Keefer, C. S., in Modell, W.: Drugs of Choice 1960-1961, St. Louis, Mosby, 1960, pp. 141, 146, 147. **5.** Huang, N. N.: J. Pediat. 59:512, 1961. **6.** Smith, R. C. F.: Brit. J. Clin. Practice 15:345, 1961. **7.** Asay, L. D., and Koch, R.: New England J. Med. 262:1062, 1960. **8.** Berry, D. G., et al.: Lancet 1:137, 1960. **9.** Osol, A., et al.: The Dispensatory of the United States of America, ed. 25, Philadelphia, Lippincott, 1960, pp. 953, 1556. **10.** Adams, A. R. D.: Brit. M. J. 1:1639, 1960. **11.** Jung, R. C., and Carrera, G. M.: Dis. Colon & Rectum 3:313, 1960. **12.** De Lamater, J. N.: Am. J. Gastroenterol. 34:130, 1960. **13.** Stewart, W. H., et al., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. II, chap. 5, p. 19. **14.** Wellman, W. E., and Herrell, W. E., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. I, chap. 44, p. 13. **15.** Wenckert, A., and Robertson, B.: Acta chir. scandinav. 120:79, 1960. **16.** Alstead, S.: Dilling's Clinical Pharmacology, ed. 20, London, Cassell, 1960, p. 462. **17.** Grover, F. W.: Texas J. Med. 57:355, 1961. **18.** Gardiner, W. P., and Gomila, R. R., Jr.: Scientific Exhibit, Venereal Disease Seminar, U.S. Public Health Service, Feb. 28-Mar. 3, 1961. **19.** Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, 1961. **20.** Nathan, L. A.: Scientific Exhibit, 15th Clinical Meet., A.M.A., Denver, Col., Nov. 26-30, 1961. **21.** Ullman, A.: Delaware M. J. 32:97, 1960. **22.** Lamphier, T.A.: Scientific Exhibit, New York State M. Soc. Meet., New York, May 7-13, 1960. **23.** Freier, A.: Paper presented at Michigan Soc. Obst. & Gynec., Detroit, May 3, 1961. **24.** Logan, K. M.: Scientific Exhibit, Ann. Meet., Ohio Acad. Gen. Practice, Cincinnati, Sept. 13-14, 1961. **25.** Altemeier, W. A., and Wulsin, J. H. (A.M.A. Council on Drugs Report): J.A.M.A. 173:527, 1960. **26.** Krol, W. J.: J. Abdom. Surg. 3:78, 1961. **27.** Potempa, J.: Med. Klin. 56:352, 1961.

In Brief

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Council, Committee Reports

Emergency Medical Services Committee

William T. Rumage, Jr., M.D., Chairman

Brown Hotel, Louisville **November 22, 1961**

Two recommendations concerning civil defense were passed at a meeting of the KSMA Emergency Medical Services Committee Wednesday November 22 at the Brown Hotel, Louisville.

The EMS Committee recommended to the KSMA Board of Trustees that it approve the medical self-help training program in Kentucky and that KSMA members should be available for consultation in the actual implementation of the program.

The second recommendation dealt with the possible publication of a special issue of the KSMA Journal on civil defense.

Other topics discussed were the medical self-help training conference which was held December 13 at Frankfort, a training workshop on civil defense held at Brooklyn N.Y. and a suggested list of first-aid supplies to be stored in a fallout shelter.

Forest Stokes, State Department of Health, presented and discussed the medical self-help training kit.

Postgraduate Medical Education Committee

Walter S. Coe, M.D., Chairman

Medical Arts Building, Louisville **November 16, 1961**

Presentation of a new type day-long course of Postgraduate Medical Education was discussed at a meeting of the KSMA Postgraduate Medical Education Committee, Thursday November 16 in the Medical Arts Building, Louisville.

In cooperation with the University of Louisville and The University of Kentucky, the PGME Committee will try to prepare and present the proposed program in one of the county hospitals with the staff of that hospital participating.

Bill Harris, director of Postgraduate Medical Education for KSMA, introduced a new calender at the meeting, the purpose of which is to decrease conflicts between medical meeting dates and provide KSMA members with an additional service.

Harris also outlined the activities of the PGME office since June 1961 and told of programs planned for the associational year.

Ben Smaller, M.D., Chicago, has joined the medical staff of the Southeastern Kentucky Baptist Hospital, Corbin. Doctor Smaller received his medical degree from the University of Illinois and took residency training in radiology at Cook County Hospital, Chicago. He has been on the faculty of the Northwestern University Medical School and was chief radiologist for the City of Chicago. He was also in charge of the Veteran's Administration radiology department and of its main 4,000 bed hospital. A diplomate of the American Board of Radiology, Doctor Smaller is certified in both diagnostic and therapeutic radiology, and is also a Fellow of the American College of Chest Physicians.

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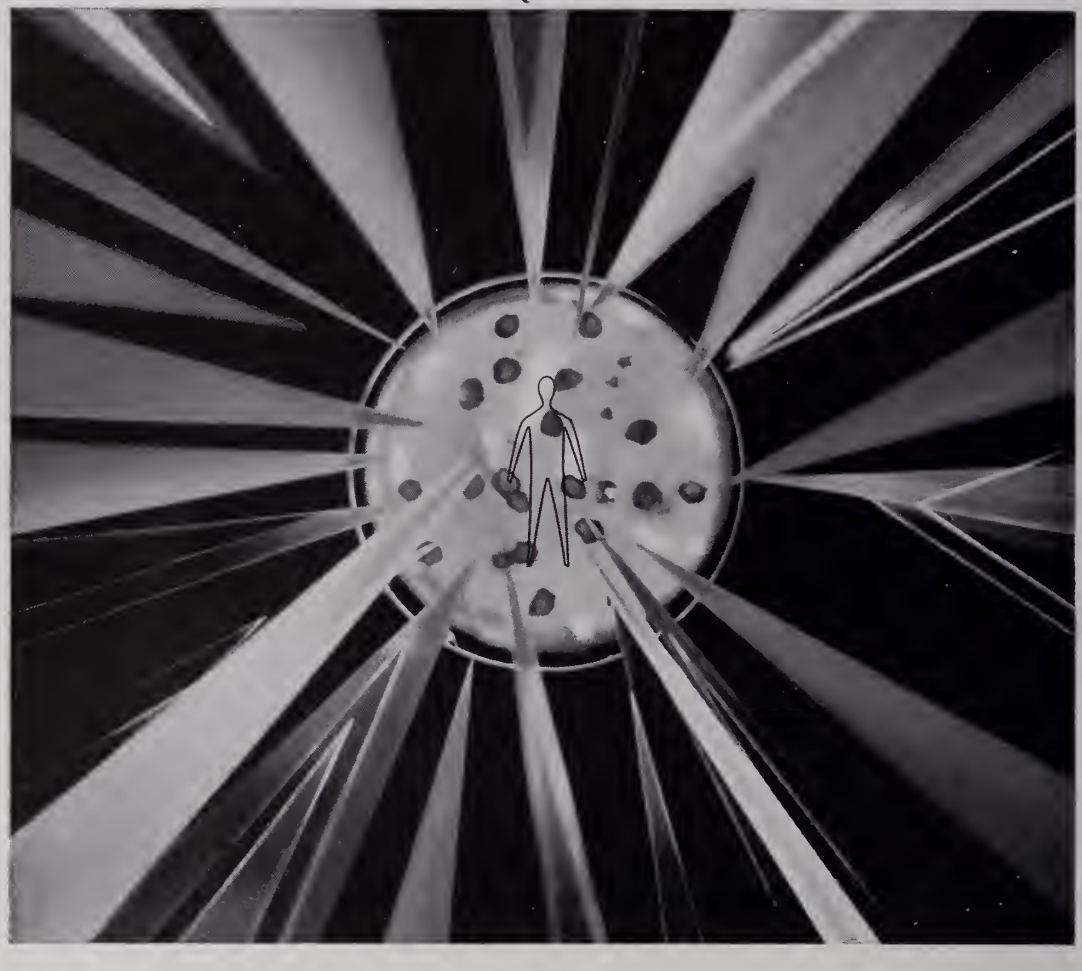
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Q.—Why should utilization of hospital facilities be of a concern to a physician?

A.—Unnecessary use increases the cost of care, and is a waste of money, time, and facilities. If the hospital facilities are not used wisely it will tend to push rates of Prepayment Plans out of the reach of those people who need the coverage most, and increase demands for government or socialized medicine. Also, beds should always be available for acutely ill patients.

Q.—What is a Service Plan and what is an Indemnity Plan?

A.—A. Under Service Benefits plan a participating Physician agrees to accept as full payment for the service rendered, the fee provided in the schedule, if the annual income of the patient is less than a specified amount.

B. Indemnity Basis—The plan will pay indemnities for specific procedures that a doctor performs.

Q.—Do I have to admit a patient to a hospital for minor surgery in order that Blue Shield will honor the claim?

A.—No. Service may be rendered in the office, home or hospital.

Q.—How many Blue Shield members in Kentucky now have the Preferred Blue Shield Plan?

A.—As of September 30, 1961, there were 72,709 members with Preferred Blue Shield.

Q.—Does the In-Hospital Medical Endorsement make an allowance on mental or psychiatric cases?

A.—Yes. The same number of doctor's calls are allowed per contract year for mental or psychiatric conditions as for any other applicable non-surgical admission. Though there are in-hospital medical endorsements sold which allow a varying number of days, the most commonly held endorsement allows 27 days per contract year.



IN THE BOOKS



THE MANAGEMENT OF FRACTURES AND SOFT TISSUE INJURIES; by the Committee on Trauma, American College of Surgeons; published by W. B. Saunders Company, Philadelphia and London; 372 pages.

As explained in the publisher's Foreword this book combines the seventh edition of An Outline of the Treatment of Fractures and second edition of Early Care of Acute Soft Tissue Injuries. There is one Index to the whole.

The book contains 372 pages, the first 137 of which are concerned with the treatment of fractures. In these 137 pages much more than treatment of fractures is discussed.

There is an excellent discussion of shock, first aid, pathology and healing of fractures, as well as treatment. A generous discussion of roentgenograms of fractures including the proper method of positioning for adequate x-ray is presented.

Many specific fractures of the more common variety are dealt with in detail. There are even short chapters on common fractures in childhood, rehabilitation, and measuring and recording joint function.

An excellent synopsis, including a remarkable amount of detail on the complete care of a fracture, is covered in Part I of this book.

Part II of the book on Early Care of Acute Soft Tissue Injuries, like Part I of the book, stresses complete examination and assessment of all the injuries of the injured patient.

This section likewise contains an excellent discussion of shock, especially the part that has to do with hemorrhagic shock.

There is a section on vascular injuries which brings the treatment of vascular injuries up to date in a concise and informative manner.

In summary, this is the best book that I have seen on the treatment of trauma. I would heartily recommend that this book be placed in every emergency room in all of the hospitals in the state and, by the same token, in every physician's office who has anything whatsoever to do with the treatment of trauma.

D. G. Costigan, M.D.

GOOD-BYE, DOCTOR ROCH; by Andre Soubiran; published by Doubleday & Company, Garden City, New York; 331 pages; price, $4.50.

Here is another story about what goes on in a psychiatric hospital, told by a "patient," in this instance, one M. Lacombe who, naturally, isn't psychotic. He has been committed as a criminally insane murderer because he won't talk. He, naturally, isn't the murderer but to establish his alibi would mar the reputation of the lady with whom he was busily engaged at the time. And, naturally, he can't do this because she is the wife of a man he hates. Another reason he won't prove his innocence is that Madame Lacombe, his wife, knows all this and naturally she understands and approves his noble stand. Is this clear so far?

Lacombe finds the hospital is not a pleasure dome and dutifully records many a gruesome detail. But he also finds the co-hero of the story, Dr. Roch, the new medical director, who, against rather fumbling opposition, sets things right in surprisingly short order. In the course of this, Madame Lacombe pitches in as a volunteer worker and first thing you know there is a love light in her eyes. So our hero begins to wonder who lit the light. Then follows the smasheroo double surprise ending which makes the book an inevitability for Hollywood or television.

None of the characters evoke any real warmth. They all seem to have a sort of schizophrenic lack of "togetherness" with the reader. I got all worn out by Lacombe's tireless, tiresome self examination.

The evils of unenlightened mental hospital care have been recorded many times. If you feel this bears repeating then this novel is your meat, and you need a change in diet.

The scene is France and the book is translated from the French. Perhaps it lost something in translation.

Jack Chumley, M.D.

THE HOUSE OF HEALING: by Mary Risley; published by Doubleday & Company, Garden City, New York; 288 pages; price $4.50.

Subtitled, "The Story of the Hospital," this book gives an historical development of the hospital from Babylon, Egypt, Greece and Rome to the great medical centers of today.

In describing the early development of hospitals in Greece and Rome, there is a minor tendency to view things as if there were "nothing new under the sun" and to equate treatment and practices then with those now still in use. The book's strongest chapters were those dealing with monastic hospitals; the relationhip of the Crusades to the development of hospitals in Rome, London, and Paris. The author also describes very graphically the relationship of hospitals to the changes in the political and social order of the times (for example, the status of hospitals in England in the 16th Century during times of great social privation). Mrs. Risley also emphasizes the increasing role of government in hospitals, both in this country and abroad.

Inevitably there is much general medical history

(Continued on Page 109)



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County Society Reports
McCracken County

The October 25 meeting was called to order at 7:30 p.m. by the president. Doctor M. Sherago of the University of Kentucky Department of Microbiology talked about antigen-antibody reactions, particularly as concerns a technique demonstrating migration of leukocytes in patients with tuberculosis as against a control group.

The business session followed: the minutes of the last meeting were not read by motion and vote. Dale Furnell, M.D., new orthopaedist in Paducah, was voted into membership unanimously—having been passed by the Board of Censors. A letter concerning "Emergency Call Plans," by N. L. Bosworth, M.D., chairman of the KSMA Council on Communications and Public Service, was read and discussed. It was decided to file this letter as it was the feeling of the society that the call program through local Paducah hospitals is adequate for the community.

A letter from the Postgraduate Medical Education Office was read concerning the qualification of Jack H. Kamholz, M.D., guest speaker on the Obstetrics and Gynecology Postgraduate Course in Paducah, November 2.

Eugene Sloan, M.D., made his report on the recent KSMA meeting in Louisville, touching on foreign graduates, osteopaths (association left up to individual physician on basis of whether osteopath in question is ethical); Blue Shield's Indiana Plan, but not called such, was passed by the House of Delegates, but left up to the individual counties as to whether they would or would not participate; recommendations were made to the control committee to re-evaluate fee schedules for surgery, hospital care, etc., before extending nursing home care under the Indigent Medical Care Program; corporate practice—the individual physician can seek tax relief by being in a corporation.

The "Indiana Plan" was discussed by Doctor Harris. Doctor Johnson reported on the "inside" of the state meeting—how the state level works, who forms the committees, etc., showing in general that a bureaucracy of "older heads" control medicine at the state level and that medicine in Kentucky is not really democratic at all. To do this he cited the men who make up the State Board of Health, their ages, and how long they had been in the same position. He also showed how Blue Shield controls who it will take, again pointing out men who had been with Blue Shield since 1945 as proof of his conclusion that Blue Shield is an autonomous corporation. Though problems confronting medicine in Kentucky have not been solved for 20 years by "those in command," the problems are too delicate and too important for "young blood." In this connection, Doctor Johnson told how there were "inadequate funds" for fighting cults and quacks at the level of the State Legislature but enough money to put up new buildings, send out postgraduate speakers where they may or may not be needed, etc. "If medicine in Kentucky is in trouble, where does the responsibility lie?"

Following the reports of Doctor Sloan and Doctor Johnson, the meeting adjourned.

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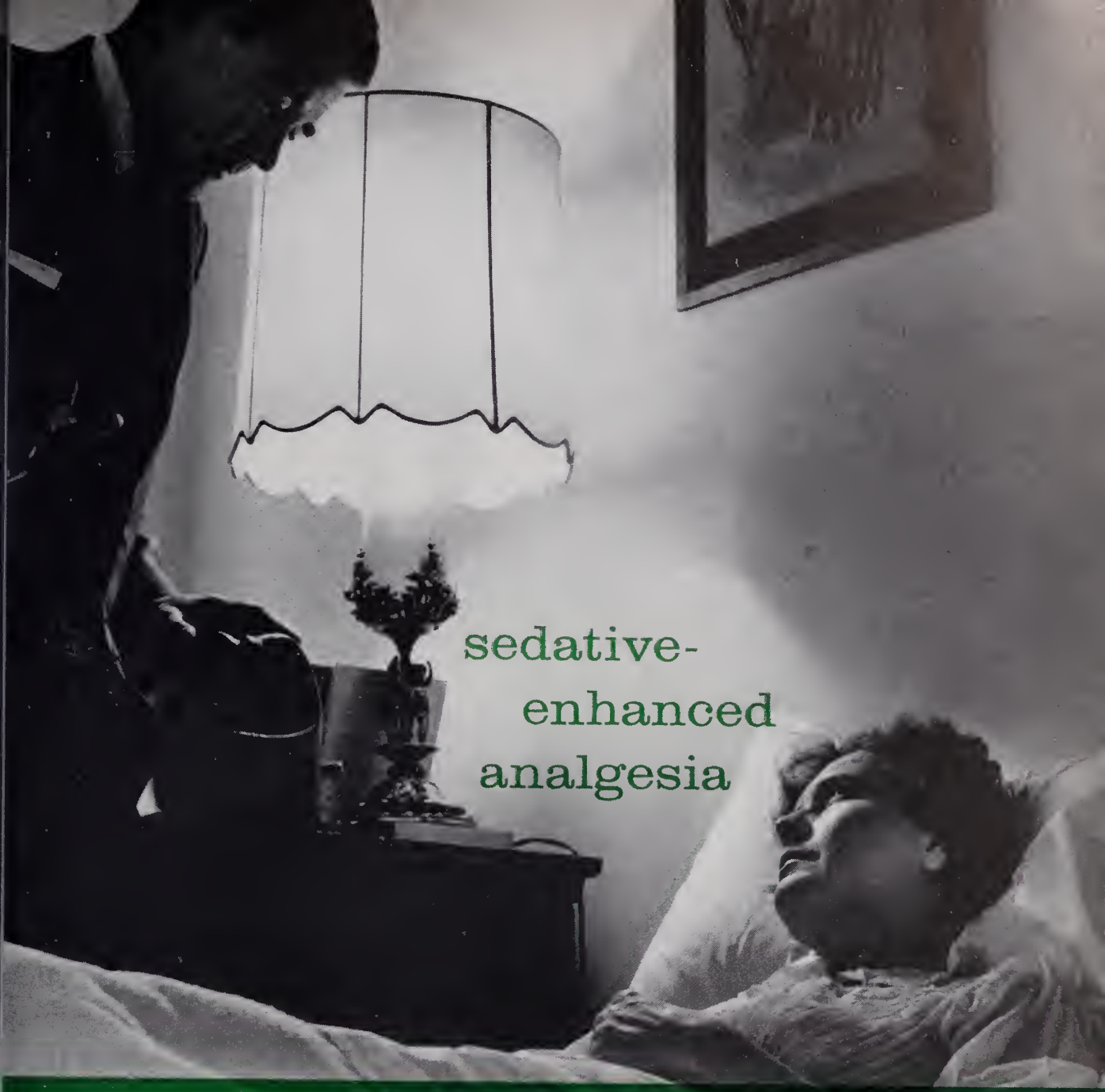
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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #100—A 26 year old married, white, gravida 3 para 3, had an uncomplicated spontaneous vaginal delivery under chloroform anesthesia of a living male infant on September 23, 1960. The placenta was expressed spontaneously and no lacerations were sustained. On the following day, the patient was afebrile and in excellent condition. She requested dismissal from the hospital so she could save on the hospital expense. As there were no apparent contraindications, she was dicharged.

She called the doctor after returning home, complaining of a headache and asking if aspirin could be taken. On the following day, she developed a rather severe diarrhea that continued throughout the day, along with some nausea and vomiting that persisted to the day before her readmission. The family had called for some medication for the diarrhea, and when it seemed to be ineffective, she was readmitted at 6:30 a.m. on September 27, 1960. She appeared acutely ill with cyanotic lips and finger nails; the blood pressure was 70/40, and her entire body was cold and clammy. The abdomen was markedly distended, and there was generalized tenderness.

Nurses' notes written between 6:45 a.m. on September 27 and 4:08 p.m. on September 28 show persistence of shock despite lavish use of vasopressor agents, digitalis, and cortisone, together with fever, often to levels of above 107°. She died at 4:08 p.m. on the second day of rehospitalization, with the signs of septicemia, shock and generalized peritonitis.

Autopsy of the abdomen revealed an adhesive exudate throughout the abdominal cavity with straw-colored fluid. The bowel loops were mutually adherent. The protocol states: "The salpinx was apparently the only source of infection, since no perforation of the bowel or stomach could be found." No further description of the findings of the partial autopsy was provided.

Comments

The committee considered this a direct obstetrical death with possible preventable factors. There was a three day period from the time she insisted on leaving the hospital until she was readmitted. Her death was from an overwhelming septicemia.

Relatively little is known about the pathologic physiology of septic shock. The therapeutic measures used are often empirical and inadequate. The most important considerations are:

(1) Early diagnosis.

(2) Correction of any deficit in the blood volume, with care being taken to avoid overloading the circulation.

(3) Intravenous administration of massive doses of the selected antibiotic agent or agents in maximum tolerated doses. This was not done in this case.

(4) Maintenance of the systolic blood pressure at 80 mm H.g. or more by an intravenous drip of levarterenol in a solution of 5 per cent dextrose and water.

(5) Hourly record of the urinary output as an index to the patient's response to the treatment with the desired goal of 25 to 75 cc per hour.

(6) Continuous administration of oxygen. (This patient's lips and fingernails were cyanotic when she was readmitted.)

(7) Elevation of the foot of the bed.

(8) Intravenous infusion of hydrocortisone if the blood pressure cannot be maintained with the administration of the levarterenol and fluids.

(9) Surgical intervention if indicated. If the primary distributing focus is an abscess, surgical drainage may be essential. The timing and selection of the proper treatment in such seriously ill patients requires the most experienced surgical judgment available.

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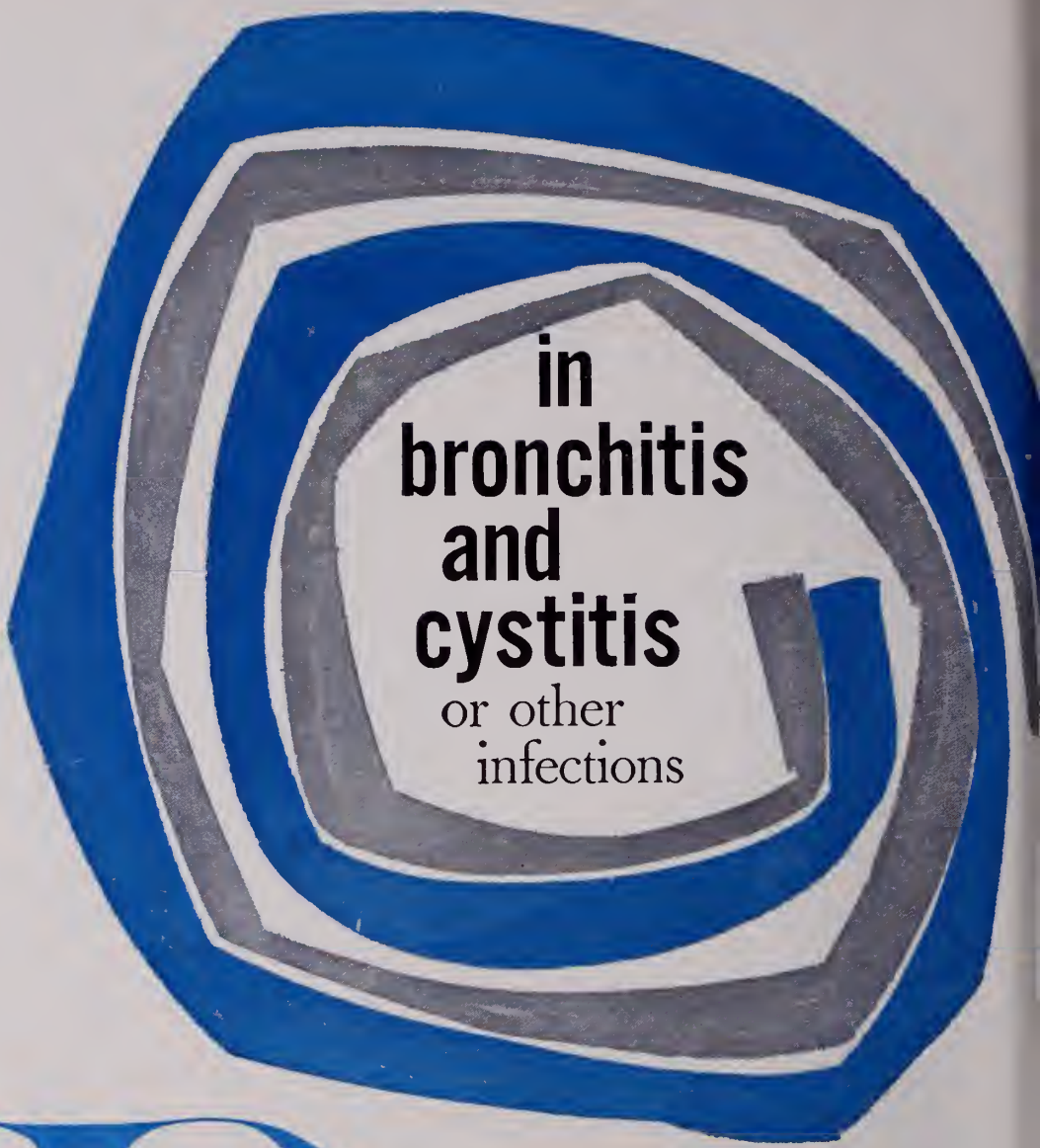
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In Memoriam

LLOYD SIMPSON, M.D.
Paducah
1884-1961

Lloyd Simpson, M.D., Paducah, died November 15 in Western Baptist Hospital. A native of Milburn, he received his medical degree from the Eclectic Medical Institute in 1909 and began practice in Lowes. In 1947, Doctor Simpson established an office in Lone Oak.

WILLIAM A. FOERTMEYER, M.D.
Bellevue
1888-1961

William A. Foertmeyer, M.D., 73, who had practiced medicine in Bellevue for 32 years, died November 20 at his home in Fort Thomas. Doctor Foertmeyer received his medical degree from the University of Cincinnati and interned at Cincinnati General Hospital. He served with the Army in World War I with the rank of Major. Active in the American Legion, he had been post physician for years.

ARCH M. CARR, M.D.
Middlesboro
1912-1961

Middlesboro physician and surgeon Arch M. Carr, M.D., Middlesboro, died November 29 at Marymount Hospital, London. He suffered a cerebral hemorrhage while returning from a trip to Louisville. Doctor Carr received his medical degree from the University of Tennessee in 1937 and moved to Middlesboro from Harlan in 1945. He had been associated in a full-time capacity with the Middlesboro Hospital from 1948 until illness forced him to retire to a limited practice in 1960.

Doctor Carr was a member of the Middlesboro School Board to which he had been elected for three terms beginning in 1951. He had served as chairman and vice chairman of that body. He was also chairman of the board of directors of the Commercial Bank in Middlesboro. During World War II he had served as a flight surgeon in Italy.

SAMUEL E. HAINLINE, M.D.
Winchester
1894-1961

A winchester physician, Samuel E. Hainline, M.D., died November 11 at the Harrison Nursing Home, Lexington, after a four months' illness. Doctor Hainline, 68, was a native of Montgomery County and was a 1924 graduate of the Medical Department of the University of Louisville.



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PUBLIC HEALTH PAGE

New Nursing Home Program In The Division Of Chronic Disease Control*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

THE Division of Chronic Disease Control of the Kentucky State Department of Health is conducting what is probably a unique program on behalf of the State's licensed nursing homes.

It may be unique in that its program is being developed and planned in cooperation with an Advisory Council of representatives of the State's Nursing Home Association.

The fact that the Nursing Home Advisory Council suggests the subjects to be given priority and assists in planning the Program, insures that the Division's approach is a practical one that will meet with general acceptance by those it is designed to assist. Members of the hospital, medical, dental and accounting professions are also assisting with the planning and training work.

Subjects on which assistance to nursing homes is being offered and for which a staff of trained consultants is available include nutrition, physical therapy, nursing service and nursing home administration. An experienced nursing home administrator was chosen for the latter position.

Plans have been laid to add to these, occupational therapy and social service work.

The primary aim of the Program is to train the nursing home staff people to conduct as many of these activities as possible and thereby permanently increase their efficiency for service.

One of the first projects, was a series of three institutes on administration, conducted in Lexington, Louisville and Madisonville under the direction of Mr. Richard D. Wittrup, Assistant Professor of Hospital Administration of the Medical School of the University of Kentucky. These institutes were well attended and very helpful.

Another, was a series of week-long staff training institutes conducted for public health nurses. At each of these, county health nurses from several counties were invited to participate so that they, in turn, could go into the nursing homes of their counties and conduct classes for nurses' aides.

In view of the possible early extension of the Medical Care Program to nursing homes, questionnaires have been sent to the nursing home administrators to ascertain if their ledger accounts are in such condition as would enable a Certified Public Accountant to determine their per diem costs of rendering care. Though the response has been encouraging, nearly all express the need for special help in adopting a uniform system of accounts. Plans are being laid to conduct a series of institutes to assist in this important matter.

A questionnaire has also been proposed to explore the staffing situation in the licensed nursing homes of the state. The Division hopes to determine whether it is possible at this time to improve the professional status of such facilities, in view of the limited available supply of professional personnel.

Further investigations in this field, may enable the Division to initiate some plan to make more licensed practical nurses available for nursing home work.

The Nursing Home Association, the Division and other state authorities have also cooperated successfully in determining uniform medical and patient record forms. The forms approved and recommended are now available within the state and we hope they will be adopted state-wide in all the nursing homes.

The object of these efforts is the welfare of the patients. To this end, the Division of Chronic Disease Control would like to emphasize, and through the medical profession to impress upon the public in general, certain basic considerations:

Only those facilities equipped and manned to properly care for the type of chronic and convalescent patients admitted, are entitled to call themselves nursing or convalescent homes or sanitariums. Such "skilled" nursing homes are licensed by the Depart-

**This article was prepared by Ira O. Wallace, Consultant on Nursing Home Administration, Division of Chronic Disease Control, Kentucky State Department of Health, Frankfort, Kentucky*

ment of Health.

Facilities not rendering skilled nursing care but rendering personal care for ambulatory elderly persons may be licensed by the Department of Economic Security only, and may be termed "rest homes," "homes for aged" or similar designations.

Bed patients should not be referred to rest homes or homes for aged. When a person living in such a facility becomes regularly bedfast, he should be transferred to a nursing home equipped to properly care for the patient, unless acutely ill, in which case he should be transferred to a general hospital.

In no case is it wise to send an elderly person or a patient to an unlicensed place, of which there are still many in our state.

With the active cooperation of our medical profession, we can do much to eliminate these unlicensed "homes" which have done so much to bring the legitimate nursing and care homes into disrepute.

In The Books

(Continued from Page 98)

woven into this story, however, the underlying theme of the book is the relationship of hospitals to the Christian sense of responsibility and accountability. It is best stated in a quotation from Rene Sand as a preface to one section: "The hospital will attain perfection when it finds its inspiration from the Comandment 'Love thy neighbor as thyself.' "

In a brief book of 285 pages, many aspects of the subject must of necessity be treated superficially, yet it does give a good perspective to the increasingly important role of the hospital in our present day medical care.

Frank M. Gaines, M.D.

Volvulus of the Cecum or Proximal Colon

(Continued from Page 54)

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SE Surgical Congress Program

(Continued from Page 67)

Forum on Developments in Nursing Care
Hartwell Wilson, M.D., Memphis, Tenn., Moderator
Richard L. DeSaussure, Jr., M.D., Memphis Tenn., Intensive Care Unit
Miss Tolbert, R.N., Baptist Hospital, Memphis, Tenn.
Walter C. Jones, M.D., Miami Fla., Recovery Room
Miss Sue Kern, Lexington, Ky.

THURSDAY, MARCH 8

Panel—"Open Heart Surgery"
J. Alex Haller, Jr., M.D., Louisville, Ky., Moderator
James D. Hardy, M.D., Jackson, Miss.
Daniel Mahaffey, M.D., Louisville, Ky.
Wendell Thrower, M.D., Charleston, S. C.
Frank Johnston, M.D., Winston-Salem, N. C.
Miss Barbara Hopper, R.N., operating room nurse
Miss Dorothy Ferguson, R.N., recovery room nurse.
Miss Molly Caldwell, R.N., Staff Nurse

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., **et al.**: Diabetes 7:398, 1958.

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported In: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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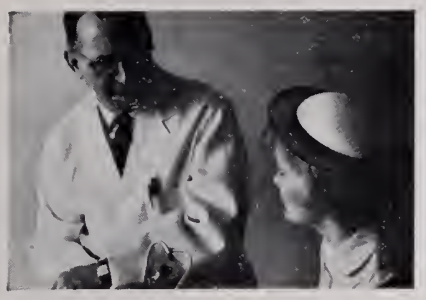
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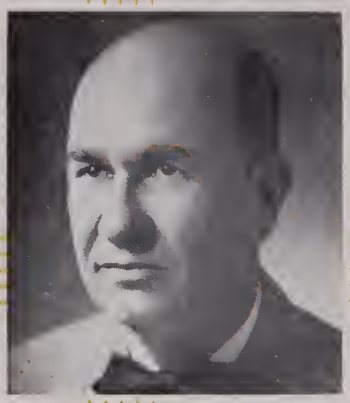
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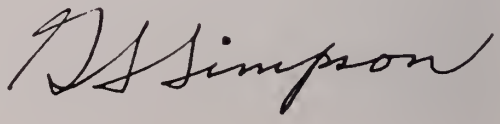
"When is a Fact a Fact?" Austin Smith, M.D., president, Pharmaceutical Manufacturers Association, Washington, D.C.

"Rumblings Along the Potomac," Wesley W. Hall, M.D., member, AMA Board of Trustees, Reno, Nevada.

"Medicine's Mission in a Changing Culture," Robert P. Varley, Th.D., Salisbury Parish, Salisbury, Md.

"Do Doctors Dare Debate?", William R. DeMougeot, Ph.D., North Texas State University, Denton, Texas.

Too late to insert in the printed program was the development that William McBeath, M.D., Frankfort, acting director, Division of Medical Care, State Department of Health, will give a 20-minute explanation of the Kerr-Mills program operation in Kentucky just before the meeting adjourns.



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This difference cannot be "proved." It must be seen. And the only practical way for you to do this is to evaluate this new drug critically in your own practice. Please do, at your first opportunity. We are confident that you will be glad you did.

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More than twice as potent as prednisolone, Alphadrol exhibits no new or bizarre side effects. Salt retention, edema or hypertension, potassium loss, anorexia, muscle weakness or muscle wasting, excessive appetite, abdominal cramping, or increased abdominal girth have not been a problem.

Indications and effects
The benefits of Alphadrol (anti-inflammatory, antiallergic, antirheumatic, antileukemic, antihemolytic) are indicated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay fever and allergic disorders, dermatoses, blood dyscrasias, and ocular inflammatory disease involving the posterior segment.

Precautions and contraindications
Patients on Alphadrol will usually experience dramatic relief without developing such possible steroid side effects as gastrointestinal intolerance, weight gain or weight loss, edema, hypertension, acne or emotional imbalance.

As in all corticotherapy, however, there are certain precautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Alphadrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

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THE INSURANCE PAGE



Major Medical Expense Protection

ONE of the newest and most rapidly growing of all of the methods of prepaying the costs of medical care is major medical coverage. The first such plan was developed in 1948 — less than 14 years ago.

In 1952 only about 1,000,000 persons were protected by major medical expense policies. By the end of 1960, nearly 27,500,000 people had major medical coverage — over 5,500,000 more than at the end of 1959. In 1960 a total of more than $430,000,000 was paid in major medical benefits by insurance companies. This was nearly $95,000,000 more than was paid in 1959.

Within the past year, major medical coverage has been added to the prepayment mechanisms offered by our own Blue Shield Plan — Kentucky Physicians Mutual. It is, of course, available only on a group basis and as a supplement to the best basic Blue Shield-Blue Cross coverages offered. Major medical will not work unless installed over good basic plans.

Major medical has come into existence in order to fill a need which is strongly felt by many people: To protect against the large loss which is unlikely to happen, as well as against the smaller loss which is more likely to happen.

Certain fundamental concepts are common to all major medical plans. One of these is the increased amount of total protection available, which may be as much as $5,000 or even $15,000 for any one illness.

Another is the fact that the protection offered is in the nature of a "blanket" which permits payment for a wide variety of benefits and services, many of which could not be covered under a basic contract. Still another feature of these plans is the use of deductible and coinsurance provisions. The deductible requirement serves to rule out the small claims for which a family can and should budget. The coinsurance idea goes into operation (usually on a 25%-75% or 20%-80% basis) once the deductible requirement has been satisfied. This serves as a check on the use of expensive but unnecessary services. Both of these features are important in keeping premiums within realistic budget limits.

The assertion is often made that present-day health prepayment is not paying a large enough portion of the total health bill. Major medical may well be a great stride forward in meeting this challenge and it may prove to be one of our most effective defenses against the socialization of medicine.

If major medical has an Achilles' heel, it is in its potential for being abused. Both the assured and the members of the medical profession must realize and accept their responsibilities in this regard. Deductible and coinsurance factors must be observed. If medical charges are increased because of this coverage, then the cause of voluntary health protection will have been hurt rather than helped.

Such abuse must be avoided at all costs, even if it should become necessary to set up mechanisms within the local, county and state medical societies to control persistent overcharging on the part of a few irresponsible physicians.

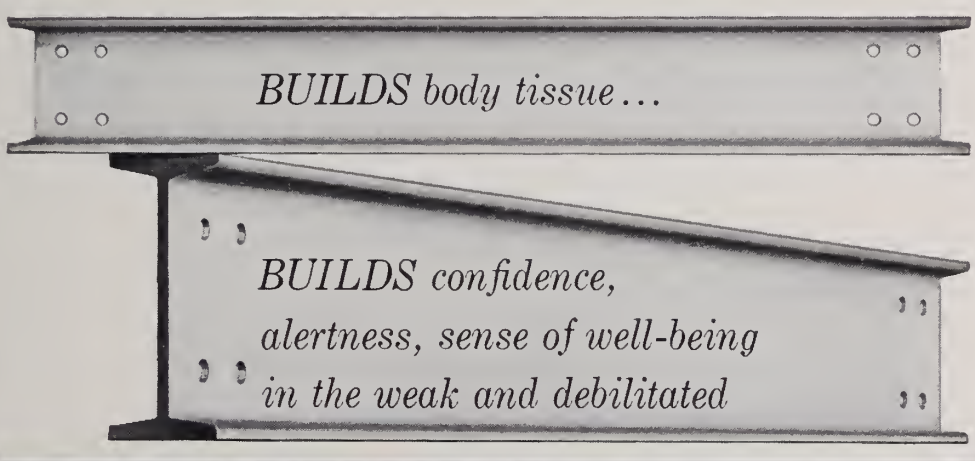
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*animal data

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

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WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—Reports by the American Medical Association and the Health, Education and Welfare Department showed that 38 states have taken advantage of the Kerr-Mills law providing medical care for the aged with a total expenditure of $121 million in the first 15 months of the program.

Citing the program's wide acceptance, Leonard W. Larson, M.D., president of the AMA said that 27 states had enacted Kerr-Mills Medical Assistance to the Aged (MAA) programs and 11 other states had expanded Old Age Assistance (OAA) medical benefits under the new law.

In addition, he said, nine states already had OAA medical programs on the books and in most instances they are considered to be adequate to provide the necessary health care for those over 65.

Two of the three remaining states—Arizona, and Delaware—have excellent assistance programs at the local level which include medical care, Dr. Larson said.

"These figures certainly contradict statements by Kerr-Mills critics who say that the program can't and won't work," Dr. Larson said.

"In just 15 short months Kerr-Mills has been widely accepted across the land and with each passing day is proving that it can, and if given the fullest opportunity, will do the job.

"Kerr-Mills is being implemented by the states as fast, if not faster, than any previous federal-state matching program.

"Such rapid acceptance of this principle makes any compulsory health program through the social security mechanism totally unnecessary."

A variety of new approaches to better care for the chronically ill and aged will be made possible through the Community Services and Facilities Act of 1961, HEW said. The Act authorizes grants to community agencies to develop new and improved home nursing, home care, and other out-of-hospital services. The Act also raises the ceiling for grants to the states for the construction of nursing homes from $10 million to $20 million annually.

Under the Hill-Burton program, 535 hospitals, nursing homes, rehabilitation centers, and other facilities were awarded $146,330,000 in Federal funds toward $468,661,000 of construction in 1961.

*** ***

Manufacturers accepted a congressional proposal for further government controls over the efficacy of prescription drugs, but stood pat in opposing patent provisions of the controversial drug legislation sponsored by Sen. Estes Kefauver (D., Tenn.).

Eugene N. Beesley, chairman of the board of the Pharmaceutical Manufacturers Association, said that the PMA "fully endorses the principle that a drug should be effective for the uses that a manufacturer claims for it; and, second, that the Food and Drug Administration, in passing on new drug applications to determine the safety of the new product, already evaluates—in many cases,—the evidence of its effectiveness for the uses claimed."

"Since FDA has expressed a desire to have its authority clarified with respect to its consideration of the effectiveness as well as the safety of new drugs, we wish to support the proposal as we understand it," he added.

Beesley said such FDA clearance "would assure physicians that a drug effectively produces certain physiological actions; but the physician, not the FDA, would determine whether these specific physiological effects would be useful or beneficial with respect to particular patients."

Beesley said the patent restrictions proposed in the bill "would virtually destroy the patent system with respect to medicines."

"This proposal obviously strikes directly and crucially at the industry's capacity and incentive for discovery of new and improved medicines, and we vigorously oppose it," he said.

Kefauver indicated he might compromise on the patent provision, saying that he was "not irrevocably wedded to the precise approach" of his legislation.

Kefauver endorsed AMA's expanded drug information program which will put the data directly in the hands of prescribing physicians in contrast to new FDA regulations which place the emphasis on distribution of new drug information to pharmacists.

"The PMA is supporting and, I trust, will continue to support the new and broadened program it has established with the American Medical Association of disseminating to physicians better and more accurate information concerning the bad as well as the good features of drugs," Kefauver said.

"And it is supporting, and again I trust will continue to support, the new program of the U.S. Pharmacopoeia and the AMA in establishing simpler and more usable generic names for drugs.

"These are important steps forward."



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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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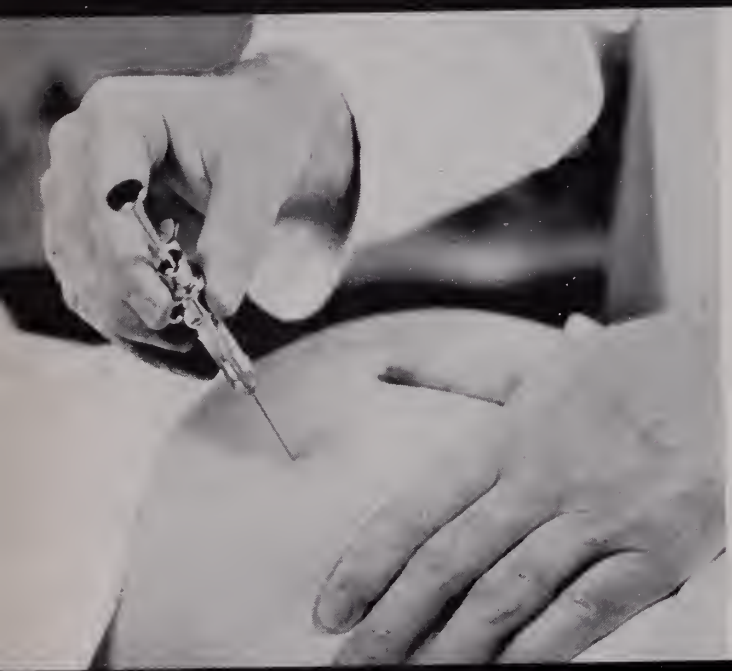
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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. **2.** J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. **3.** J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. **4.** W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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PLAN TO ATTEND
March 28 and 29, 1962

The Brown Hotel—Louisville, Kentucky

8th Annual Symposium On Cardiovascular Diseases

WEDNESDAY, March 28, 1962
MORNING SESSION:

Presiding—F. ALBERT OLASH, M.D., Chairman, Symposium Committee.

"Shock"

JACK CROWELL, Ph.D., Department of Physiology, University of Mississippi, Jackson, Mississippi.

"Cardiovascular Collapse"

MAX SADOVE, M.D., Professor of Surgery, Head, Division of Anesthesiology, University of Illinois, Chicago, Illinois.

"Heart Block"

SIDNEY P. SCHWARTZ, M.D., Associate Clinical Professor of Medicine, Columbia University, New York, New York.

Panel on *"Cardiovascular Collapse"*

WALTER S. COE, M.D., President Heart Association of Louisville & Jefferson County, Moderator, DRS. CROWELL, SADOVE and SCHWARTZ.

AFTERNOON SESSION:

Presiding—MARC J. REARDON, M.D., President, Kentucky Heart Association, Covington, Kentucky.

"Newer Concepts of Coronary Heart Disease"

WILLIAM LIKOFF, M.D., Director, Cardiovascular Section of the Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

"The Physician Looks at the Surgery of Acquired Heart Disease"

DWIGHT HARKEN, M.D., Associate Clinical Professor of Surgery, Harvard Medical School, Boston, Massachusetts.

"Alveolar Hypoventilation in the Pathogenesis of Cor Pulmonale"

ALFRED P. FISHMAN, M.D., Associate Professor of Medicine, Columbia University, College of Physicians and Surgeons, New York, New York.

Discussion

DINNER MEETING

Speaker — JESSE STUART, Author and Poet Laureate, Greenup, Kentucky.

THURSDAY, March 29, 1962
MORNING SESSION:

Presiding—JACK CHUMLEY, M.D., President-Elect, Heart Association of Louisville & Jefferson County.

"Medical and Surgical Treatment of the Incipient Stroke."

JACK WHISNANT, M.D., Assistant Professor of Neurology, Mayo Clinic, Rochester, Minnesota.

"Surgery in the Treatment of Strokes"

E. STANLEY CRAWFORD, M.D., Associate Professor of Surgery, Baylor University College of Medicine, Houston, Texas.

"Anticoagulation in the Treatment of Patients with Stroke"

FLETCHER MCDOWELL, M.D., Visiting Physician in charge, Cornell Neurological Service, Bellevue Hospital, New York, New York.

Panel on "Cerebral Vascular Diseases"

EDMUND D. PELLEGRINO, M.D., Moderator, Professor and Chairman, Department of Medicine, University of Kentucky College of Medicine, Lexington, Kentucky.

DRS. WHISNANT, CRAWFORD and MCDOWELL.

AFTERNOON SESSION:

Presiding—BEVERLY T. TOWERY, M.D., Professor and Chairman, Department of Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"Auscultation and Phonocardiography"

ALDO A. LUISADA, M.D., Research Professor and Head, Division of Cardiovascular Research, Chicago Medical School, Chicago, Illinois.

"Auscultation"

J. SCOTT BUTTERWORTH, M.D., President, American Heart Association, Associate Professor of Medicine, New York University School of Medicine, New York, New York.

Clinical Pathological Conference

IRA GORE, M.D., Moderator, Chief, Laboratory Services, Veterans Administration Hospital, West Roxbury, Massachusetts.

Professor of Pathology, Boston University Medical School, Chief of Pathology, Massachusetts Memorial Hospital, Boston, Massachusetts.

Participants: Doctors IRA GORE, J. SCOTT BUTTERWORTH, JOSEPH P. HOLT, and WOODFORD B. TROUTMAN.

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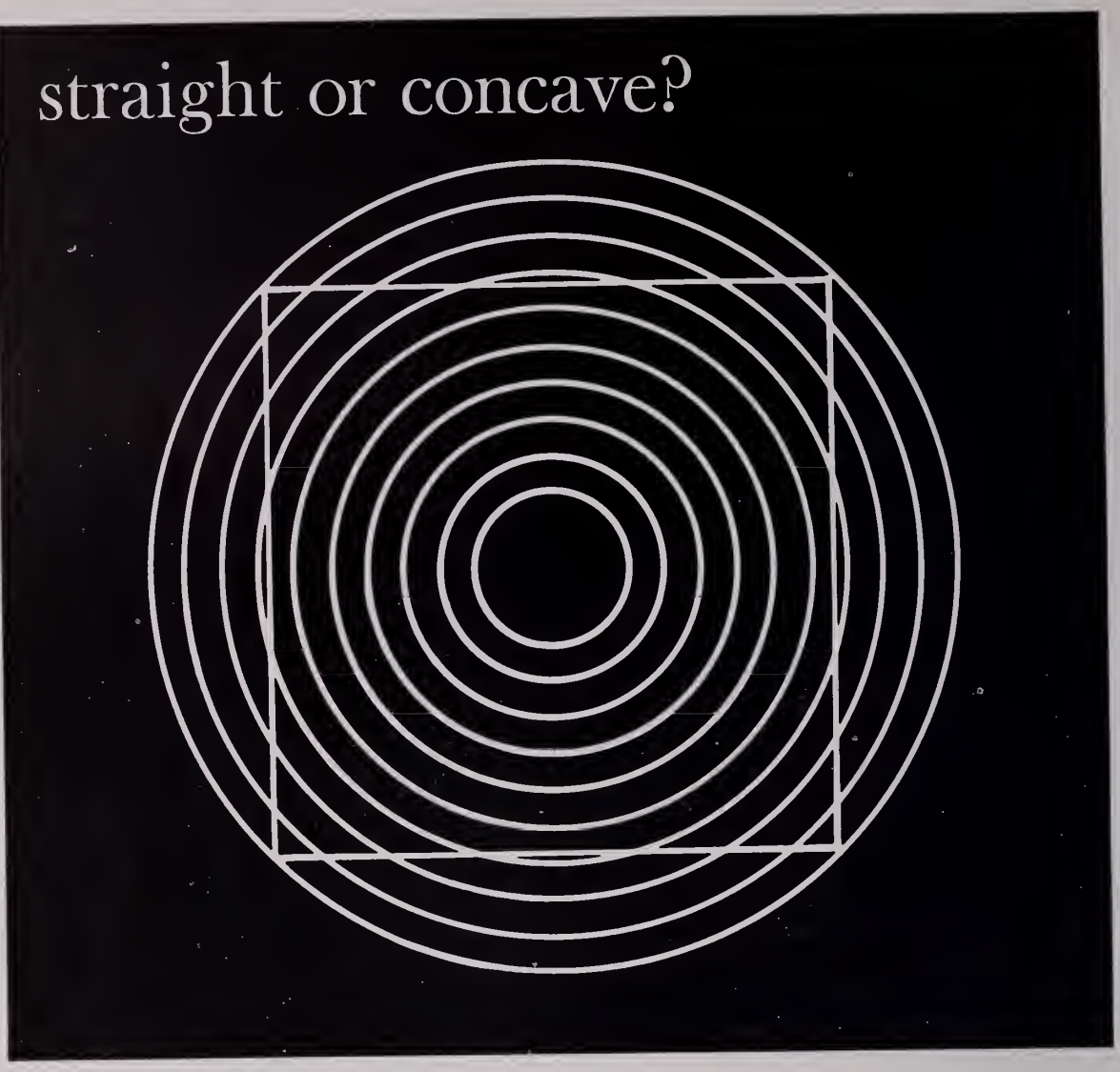
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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 60 FEBRUARY, 1962 NO. 2

The Superior Mesenteric Artery Syndrome

GILES L. STEPHENS, M.D., F.A.C.S.*

Louisville, Ky.

The clinical picture of this rare but interesting syndrome is given. Relationship of symptoms and their relief by change in body position is emphasized. Therapy is discussed.

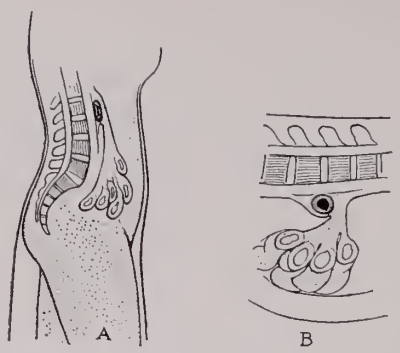
IN 1861 Rokitansky described the mechanism of acute dilatation of the stomach as being due to compression of the duodenum by the mesenteric vessels.[10] Albrecht is given credit for the modern concept of the pathogenesis of arteriomesenteric obstruction. He reported two cases in 1889 of chronic duodenal obstruction and observed flattening of the duodenum between the mesenteric pedicle and the spine.[1] In 1900 Petit[9] presented two drawings to support his theory that duodenal obstruction was due to traction on the mesentery of the small intestine and stated that the condition was an exaggeration of a normal anatomic relationship. Petit was the first author to suggest a duodenojejunostomy to correct this condition. In 1908 Codman[3] compared the arteriomesenteric crotch of the quadruped posture and the erect posture in man. (Fig. 1) He stated that the arterial crotch in man became closed when the body was in the erect position because of the vertical position assumed by the mesentery and that anatomical variations from the normal would increase the pressure to the extent of causing compression of the duodenum. Partipilo states that arteriomesenteric obstruction is in reality an accentuation of a normal condition; hence, basically it is congenital, while the predisposing factors are usually acquired. Partipilo[6] listed the following predisposing factors:

1. Ptosis of small intestine due to loss of mesenteric fat. (Fig. 2)
2. Abdominal relaxation following pregnancy and debilitating diseases.
3. Ptosis of the large bowel.
4. Lordosis of the lumbar spine.

Clinical History

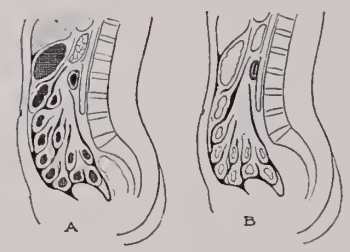
The history of the patient to be discussed revealed an illness of long duration. Many patients date their complaints from childhood. This syndrome occurs more often in the female than in the male (by a ratio of three to one). These patients are usually of the visceroptotic type, asthenic, thin individuals with scaphoid abdomens. Most of them have had previous medical treatment for stomach trouble. The majority of cases reported in the

*Instructor in Surgery, University of Louisville School of Medicine. Surgical Staff, Methodist Evangelical Hospital, Louisville, Kentucky.



Comparison of the arteriomesenteric crotch in the quadruped (*b*) posture and the erect posture in man.

Figure 1*



(*a*) Shows the normal relationship of the spinomesenteric triangle; (*b*) narrowing of the triangle with compression of the duodenum as a result of loss of mesenteric fat.

Figure 2*

surgical literature fall in to the third decade of age. Kaiser, McKain and Shumacker[5] state that there are two distinct clinical types, the acute and the subacute or chronic. Vomiting is the most characteristic symptom according to Partipilo; it is generally intermittent and the vomitus contains enormous quantities of bile. The attack may last for several hours or for days depending upon the degree of duodenal obstruction. At times the vomiting is relieved by assuming the knee-chest position or by lying on the abdomen or on the right side. Partipilo stresses that this is a significant factor to elicit in the patient's history and recommends a therapeutic test by having the patient rest in bed with the foot of the bed elevated 18 inches in order to bring relief. In Kaiser, McKain and Shumaker's series of 11 patients with the chronic type, all had intermittent abdominal pain or postprandial epigastric fullness and the vomitus usually contained recently ingested food. All of the patients of the acute type in this series had been confined to bed because of illness, injury or surgical procedure, usually for a period of weeks to months. The abdominal pain is epigastric in position and varies from a mild discomfort to a sharp colicky pain. The pain characteristically subsides after vomiting. The pain in duodenal obstruction is probably due to the distended duodenum and to the unyielding, spastic pylorus. When the pylorus yields, the duodenal contents empty into the stomach and the patient vomits. According to Partipilo the attacks in the chronic form may not be particularly severe until early adult life when a debilitating disease is followed by loss of mesenteric fat or frequent pregnancies or abdominal wall relaxation.

Figure 1 and 2 reproduced with permission of Doctor V. A. Partipilio and Lea and Febiger, publishers.

X-ray Findings

Plain roentgenograms of the abdomen will show gaseous distention of the stomach and duodenum, with little or no gas beyond the point of obstruction. Anatomically, this is usually close to the lateral border of the right iliopsoas muscle. According to Kaiser, McKain and Shumacker, cholecystography may indirectly lead one to suspect some type of duodenal obstruction if the dye opacifies the stomach and duodenum or if the gallbladder reopacifies over a period of days. Careful upper G. I. x-ray studies will confirm the diagnosis in practically every case. It should be emphasized, however, that if these studies are made in between the attacks, when the patient is symptom free, the roentgenographic observations may be negative. The typical roentgenographic observations were first reported by Jordan[4] in 1911.

Although peptic ulcer is said to be a frequent concomitant disease, it was not present in any of the cases of Kaiser, McKain and Shumacker. Gastric analysis was obtained in a few of the cases studied by Kaiser, McKain and Shumacker and was either normal or a lack of free and low total acid was found. This was attributed by the authors to the bile regurgitation into the stomach.

According to Henry Bockus[2] there are no characteristic changes in the gastric acidity in patients having arteriomesenteric occlusion of the duodenum. Half the cases studied by Bockus had hyperacidity and half had normal acidity or hypochlorhydria. He found that biliary regurgitation into the stomach was pronounced in 45 per cent. Another important finding was the presence of food residue in the proximal duodenum following a sixteen hour fast in one-third of this series of cases. Of Wilkie's 75 surgically verified cases of mesen-

teric occlusion, 19 (25%) showed a coexisting duodenal or gastric ulcer. Bockus said, "which is the cart and which is the horse in the combination of peptic ulcer and duodenal stasis has not been established." Approximately 20 per cent of cases of mesenteric occlusion of the duodenum have or have had an ulcer in the stomach or duodenum.

Treatment

According to Partipilo the treatment of the chronic form is preferably medical. The objective of medical treatment is to increase the mesenteric fat content in order to move the small intestine upward and forward, thereby relieving the backward and downward traction of the mesenteric pedicle. This can be accomplished by postural rest in bed, high caloric, high fat, and high carbohydrate diet and abdominal exercises. Partipilo also advocates having the patient rest and sleep with the foot of the bed elevated 12 to 18 inches to permit the small intestine to migrate into its normal position and thereby relieve the duodenal obstruction. He lists the following criteria used to decide the question of surgical operation: (1) failure of medical treatment to relieve the symptoms after prolonged trial; (2) inability of the patient to gain weight after three months of postural and medical treatment; (3) duodenal retention as shown by a five-hour x-ray film; (4) persistent vomiting during medical treatment; (5) recurrent attacks of vomiting; (6) when the cause of the obstruction is due to an intrinsic or extrinsic tumor. Both Shumacker and Partipilo state that the surgical operation of choice is a duodenojejunostomy. This is the only surgical procedure which adequately and thoroughly drains the obstructed duodenum. Gastrojejunostomy has been suggested in the past, but this operation is inadequate.

E. K. Strong[11] states that the ascending limb of the duodenum is compressed between the superior mesenteric artery and the anterior right lateral aspect of the aorta. The involved portion of the duodenum is immobilized in this constricting vice of these two vessels by its peritoneal attachments and the ligament of Treitz. Strong advocates cutting these peritoneal attachments and the ligament of Treitz, thus freeing the ascending duodenum.

Williams and Bowers[12] state that a duodenojejunostomy is not rational treatment for the patient who has arteriomesenteric duodenal obstruction associated with a duodenal ulcer because the proximal duodenum is already severely diseased. These authors recommend subtotal gastrectomy with gastrojejunostomy as the treatment of choice for a patient with extensive scarring of the proximal duodenum. For a mild peptic ulcer they advocate gastrojejunostomy as technically easier than a duodenojejunostomy and allowing healing of the ulcer by diverting the gastric acid. I recommend duodenojejunostomy for arteriomesenteric duodenal obstruction and in those cases with associated duodenal ulcer I recommend duodenojejunostomy plus abdominal vagotomy and Heineke-Mikulicz pyloroplasty.

Case Report

Case #1796, B. McC.—Present Illness: This 22 year old white male automobile mechanic stated that ever since he was six years old he had noted dull aching pain in the midepigastric region. He could relieve this pain by squatting or lying over a log; if he would lean forward this would also relieve the pain but to a lesser degree. For an unknown period of years he noted that the pain would be aggravated if he were to lie flat on his back. Vomiting would relieve the pain usually for a twenty-four hour period. The vomitus was most frequently bile stained. The onset of pain was most frequent at approximately 3 p.m. There was no specific radiation of pain into his back. In 1955 the patient noted that milk would relieve this pain. He would usually have two formed stools per day. He denied hematemesis, melena and passage of bright red blood per rectum. At no time had the patient noted the sensation of gastric fullness. He had been treated by several physicians in the past for "nervous stomach" but no upper G. I. series x-ray examination had ever been obtained. He further stated that he never has been able to gain weight properly. On 12-21-60, the patient had an acute exacerbation of pain and was referred by his physician to Louisville for diagnostic studies. The patient had been able to retain only a limited amount of food during the three weeks period prior to his admission to the hospital.

Past History: Patient had bronchoscopy and bronchography at the St. Joseph Infirmary, Louisville, in 1947, which revealed bilateral

bronchiectasis. Hospitalized at the Ft. Knox Army Hospital in 1958 for pulmonary hemorrhage; he required blood transfusions. Patient consumed one case of beer on an average of every other week-end for the past six years.

Physical Examination: Temperature: 97.6. Pulse: 104. Respiration: 18. Blood Pressure 150/96. General Appearance: Fairly well developed, fairly well nourished, white male with asthenic build. Appearing chronically, but not acutely ill, and emotionally tense.

Lungs: A few moist rales in both lower lobes.

Abdomen: Scaphoid. Liver, spleen and kidney not palpated. Hyper-resonant percussion note in the right upper quadrant of the abdomen. One plus tenderness in the mid-epigastric region only and no rebound tenderness. Peristalsis active but of a normal pitch. No rigidity, no definite masses palpated.

Extremities: Slight cyanotic hue to the fingernails but no definite clubbing of the fingers.

Laboratory Examinations: Hemoglobin: 11.9 grams %. Hematocrit: 40%. WBC 10.900 with 85% Neutrophils, 14% Lymphocytes, 1 Eosinophil.

Urinalysis: Essentially negative. V. D. R. L.: Negative. Total Protein: 7.9 grams %. Albumin: 3.9. Globulin: 4.0. Sputum culture yielded Alpha streptococcus and Hemophylus influenzae. Both of these were sensitive to Penicillin, Streptomycin, Erythromycin and Chloromycetin.

Chest X-ray: Revealed an irregular infiltration in both lower lung fields consistent with pneumonia. Bronchiectasis would be considered.

Upper G. I. Series and Small Bowel Study: The esophagus and stomach were normal. The first portion of the duodenum was constantly and markedly deformed and an active ulcer crater was demonstrated. The descending duodenum and a portion of the third part of the duodenum were seen to be moderately dilated. In the third portion of the duodenum there was an abrupt change to normal diameter of the duodenum. The deformity was fairly typical of a superior mesenteric artery compression (Fig. 3). There was complete emptying of the stomach after three hours and at that time the head of the barium column was in the transverse colon.

Progress in Hospital: The patient was admitted to the Methodist Evangelical Hospital,



Figure 3. Upper gastrointestinal series showing superior mesenteric artery compression of the third portion of the duodenum with partial obstruction.

Louisville, Kentucky on 1-15-61, at which time history and physical examination plus routine laboratory examinations were obtained. The patient was placed on a Sippy one diet, plus Pro-Banthine® and Gelusil® and sedated with sodium phenobarbital. The patient was given one pint of blood on three consecutive days to correct his known contracted blood volume. After postural drainage, bronchoscopy and bilateral bronchography was performed by Dr. John Stamer. This revealed wide spead bronchiectasis involving the left lower and right middle lobes with a lesser degree of bronchiectasis involving the lingula. Upper G. I. series and small bowel study revealed a chronic active duodenal ulcer and superior mesenteric artery compression of the third portion of the duodenum. On 1-20-61, abdominal exploration revealed distention and dilatation of the duodenum proximal to the middle of its third portion. The obstruction was caused by the superior mesenteric artery and its mesentery compressing the third portion of the duodenum (Fig. 4). The duodenum distal to the site of obstruction was of normal size and was collapsed. The ligament of Trietz was incised



Figure 4. Photograph of operative findings: The hemostat at the left points to the distended obstructed proximal part of the third portion of the duodenum and the hemostat on the right points to the obstructing superior mesenteric artery and its mesentery.

and the peritoneal attachments of the duodenum distal to the point of obstruction were cut and although the distal duodenum descended, I was not satisfied that the duodenal obstruction had been completely relieved. Therefore, a side-to-side duodenojejunostomy was performed. Abdominal vagotomy and an anterior gastroduodenotomy were done and the posterior wall duodenal ulcer was visualized. A two layer Heineke-Mikulicz type pyloroplasty was constructed and then a Stamm type gastrostomy was done, using a Foley bag catheter as a gastrostomy tube. The left upper quadrant paramedian abdominal incision was closed in layers with interrupted cotton sutures. There was minimal blood loss and no blood transfusions were given. The patient's postoperative course was uneventful until the seventh postoperative day when the gastrostomy tube was removed and the patient leaked gastric contents from the gastrostomy stab wound for approximately 48 hours. Nasogastric Levin tube suction was employed for 72 hours after this leak was detected. The patient was discharged from the hospital on the 13th postoperative day on a low carbohydrate, high protein, high fat diet with five moderate size interval feedings per day with liquids taken only between meals. Since discharge he has tolerated this diet well, has gained strength and weight, and has had no gastrointestinal complaints. A subsequent upper gastrointestinal series and small bowel series on 4-20-61 revealed no duodenal ulcer. The second part of the duodenum was again seen to be dilated. In the erect position a fluid level was observed at the level of the superior mesenteric compression. This did not appear to appreciably delay the passage of barium. A functioning duodenojejunostomy was seen. Deformity of the first portion of the duodenum and pylorus secondary to pyloroplasty was present. At the end of one hour and thirty minutes the barium was in the colon and only a very small amount of barium remained in the stomach.

Summary

1. The clinical picture of the superior mesenteric artery syndrome is presented.
2. The anatomy is discussed and the clinical types presented.
3. The laboratory findings and treatment are discussed.
4. A case with associated duodenal ulcer is presented.

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Correction Noted

In the article, "Volvulus of the Cecum or Proximal Colon," by George Benton Sanders, M.D., in the January 1962 issue of The Journal, in Figure 1 on page 50, the phrase "(a) radial type" should read": "(a) axial type."

Acute Intermittent Porphyria

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A rare disease with surgical connotations and no effective treatment is discussed. Symptoms, diagnosis and pathologic physiology are given. A case is reported.

PORPHYRIA, the disease inconstantly presenting pink teeth, port-wine urine, termagantism (satanic women), belly-pains and a "red herring" to unwary surgeons has enough in it to command the consideration of almost anyone.

Porphyria is a recessive Mendelian hereditary disturbance due to an inborn defect of pigment metabolism. The porphyrins are found in fossil fecaliths and in petroleum, a fact which supports the theory that the pigments may be the agents responsible for the prehistoric change from anaerobic life in an oxygen-less atmosphere to aerobic, and subsequently mammalian life, as anaerobic organisms gradually oxygenated the atmosphere via the iron-porphyrin, heme, or the magnesium-porphyrin, chlorophyl. Iron-porphyrin or heme transports and stores oxygen and catalyzes the oxidation of cellular constituents, releasing energy. Porphyrins are found in the body both free and combined with hemoglobin, myohemoglobin, cytochromes and catalase. We are concerned diagnostically with uroporphyrin and coproporphyrin, isomers I and III, and porphobilinogen.[1, 2]

Responsibility for the production of the abdominal and nervous system symptoms of acute intermittent porphyria is assigned by Watson to porphobilinogen[3] which the liver fails to convert to porphyrins. Urinary porphobilinogen is colorless but changes to the brownish colored porphobilin when the urine is exposed to sunlight. Uroporphyrins and coproporphyrins, when excreted in pathological amounts, cause the urine to become reddish-black in color. The type I isomers of uroporphyrins and coproporphyrins cause light sensitivity of the skin consisting of a vesicular eruption, pigmentation, and scarring. The type III isomers, when abnormally excreted in acute porphyria, are associated with abdominal and nervous symptoms but light sensitivity is absent. The term porphyrinuria is applied to the condition in which increased porphyrin formation, predominately coproporphyrin, is due to hepatic disease, such as cirrhosis of the liver, obstructive jaundice, infectious hepatitis, pernicious and hemolytic anemia, leukemia, Hodgkin's disease, anaplastic anemia, drug and chemical toxicities such as result from sulfa, anesthetics, barbituates and alcohol ingestion.[3]

Clinical Manifestations

This is an uncommon, chronic disease found in both sexes and in all age groups, which may have acute phases and in which symptoms referable to the various body systems and the psyche may occur singly or in combination at various times.[1, 2, 3, 4, 5]

Abdominal Symptoms: usually severe localized or generalized colicky pain is present with diverse onset and duration. The pain is inconstantly associated with nausea and vomiting. Abdominal tenderness may be present but the abdomen is soft and there is no rebound tenderness. Surprisingly severe degrees of distension may be encountered. X-ray examination findings customarily encountered are di-

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lated small and large bowel, impacted feces, and occasional fluid levels suggestive of intestinal obstruction.

When obstipation is severe (and some degree of obstipation is considered to be characteristic of the disease) the film of the abdomen may show bowel distension, especially of the large bowel, which is convincing with respect to the diagnosis of intestinal obstruction.[4]

Psychiatric Symptoms: Psychiatric symptoms are seen in over three-fourths of the patients.[5] They consist of insecurity, hysteria, epileptiform convulsions, visual disturbances, dream states, "petit mal" phenomenon, suicidal tendencies, and apathy. Certain female personality types are designated termagantism by Kark,[2] a term derived from the word termagant meaning a virago.

Neurologic Symptoms: These consist of weakness, parasthesias, muscular atrophy, pains in the extremities and back, areflexia, convulsions and cranial nerve deficits.

Vascular Symptoms: These consist of intermittent low grade fever and tachycardia, and intermittent hypertension.

Diagnosis

Acute intermittent porphyria may be confused with combat fatigue, hysteria, pheochromocytoma, appendicitis, glomerulonephritis, muscular dystrophy, and delerium tremens. The diagnosis is a possibility in the presence of abdominal pain with minimum signs, a peripheral neuropathy, continued psychotic symptoms, many laparotomies with persistence of pain, and passing of dark urine. The definitive diagnosis depends on the demonstration of porphobilinogen or uroporphyrins in the urine. The test for porphobilinogen is almost always positive in intermittent acute porphyria, rarely positive in mixed porphyria, and never positive in porphyrinuria. Red urine containing larger amounts of uroporphorins is characteristic of the photosensitive types. The urine of intermittent porphyria is more brown and less red. Seide[6] found that in 70% of patients with acute intermittent porphyria if the urine is not dark during the attack it will change to a dark Coca-Cola color on standing in the sunlight for several hours. 80% have positive tests for porphobilinogen and the remainder will have uroporphyrins in the urine. Markowitz[5] states that if the Watson-Schwartz test for porphobilinogen is positive and the patient is not photosensitive it almost certainly indicates the presence of acute intermittent porphyria. Redeker[7] states that the Watson-Schwartz test for acute porphyria may require some confirmation under certain circumstances. The presence of melanogen in cases of melanosarcoma may result in a false positive as will the ingestion of pyridium. Large excesses of urobilinogen may interfere with the test. The author outlines the presumptive and confirmatory tests.

Selected Cases

The outlining of selected cases of this uncommon disease may furnish valuable background information. Addison[3] discusses six cases having clinical manifestations which would be acceptable generally as representing intra-abdominal disease requiring urgent surgical consideration although hypotension and vital deterioration apparently was not characteristic of this group while, as it will be seen subsequently, this was the essence of our case.

In brief, one case presented abdominal pain, marked generalized abdominal rigidity, fever, marked normally differentiated leukocytosis, a negative abdominal scout film, a negative laparotomy and a positive urinary porphobilinogen and uroporphyrin test.

Another case presented symptoms and signs of either acute pancreatitis or perforating ulcer subsiding within 24 hours, a negative neurological examination, X-ray findings of gas and fecal material scattered throughout the colon and small intestine and the first of four daily tests for porphobilinogen and uroporphyrin were positive for porphobilinogen and negative for uroporphyrin.

Still another case revealed abruptly begun cramps and abdominal pain, fever, slight abdominal distension, generalized tenderness and muscle guarding most marked in the right lower quadrant with right-sided rebound and rectal tenderness, a normally differentiated leukocytosis, and, at laparotomy a normal appendix and a granular, edematous and inflamed terminal ileum filled with gas and liquid feces. The urine was examined for all three porphyrins. Coproporphyrin was present on the second day and porphobilinogen and coproporphyrin on the third day. Porphobilinogen was present daily until the sixth day.

In another case a history was presented com-

patible with subacute cholecystitis, with fever, tenderness, muscle guarding and splinting in the right upper abdominal quadrant, icterus and a normally differentiated leukocytosis. The test for all three urinary porphyrins was positive. Abnormal X-ray findings consisted of an occasional bubble of gas in the small bowel suggesting intra-abdominal irritation with ileus and non-visualization of the gall bladder. Laparotomy revealed cholecysto- and choledocholithiasis. The porphyria was thought to be mainly of prognostic importance.

Another case presented symptoms of acute appendicitis, marked right lower quadrant abdominal tenderness and splinting, leukocytosis, positive urinary porphobilinogen and coproporphyrin. A definitely inflamed appendix was removed. This was thought to be a possible case of latent porphyria activated by acute appendicitis. The final case revealed manifestations of bilateral urinary track infection, hematuria, pyuria, porphorobilin-ogenuria and uroporphyrinuria, and pneumonitis which may have activated the porphyria. Watson[4] presents a case of volvulus and gangrene of the cecum and an opinion that disturbances of the motor function of the bowel secondary to porphyria may result in a critical intra-abdominal catastrophe such as volvulus which requires a surgical maneuver for the maintenance of life.

Pathologic Physiology

Angiospasm has been proposed to explain the gastro-intestinal as well as some of the other symptoms. Pain, constipation and vomiting are characteristic findings. X-ray examination may show localized or generalized constriction or dilatation of any part of the gastrointestinal tract. Spasm of the entire bowel and dilatation of the stomach and duodenum and repeated blanching of the bowel, followed by spasm in localized areas has been observed directly. Direct application of porphyrins to the bowel produces a spasm unrelieved by atropine.[8] In some long-standing cases of porphyria, marked wasting, pigmentation of skin and mucous membranes are associated with low levels of sodium and chlorides in the blood and a high intercellular sodium and low intercellular potassium in muscle. This deficit does not respond to the administration of natural or synthetic adrenal hormones.[2]

Treatment

The treatment is medical. There is no specific treatment. Demerol® is used for cramps and tetraethylammonium chloride may be administered for the pain of the neuropathies. Prostigmin, sympathectomy, massive therapy with vitamins, liver preparations and adrenocortical hormones have been reported to be of benefit. Corticotropin or adrenal steroids should be used in fulminating acute porphyria. Barbiturates should be avoided.[2] Water and electrolyte deficits should be corrected. The mortality rate may be 50 to 90% in an acute episode.[8]

Case Presentation

A.M. Admitted 2-23-61. History of Present Illness: Twelve hours prior to admission this 45 year old negro housewife noticed a sudden onset of severe, generalized abdominal pain of a crampy nature. The cramps became worse progressively throughout a sleepless night. The patient had no bowel movement and had passed no flatus for a period of 24 hours prior to admission. It was unusual for the patient to be constipated. A few minutes prior to admission she became nauseated and vomited once, producing undigested food. For approximately two hours prior to admission the cramps became definitely intermittent and the pain built up to a high degree of intensity and waned every few minutes. She had taken no solid food or liquids since the onset of the pain. During her menstrual periods she had abdominal cramps lasting several hours which she did not think were menstrual cramps. The onset of these attacks was six to eight months prior to admission. During this attack she thought her abdomen was gradually swelling.

There was no history of indigestion, other types of abdominal pain, hematemesis, melena, jaundice, anorexia or weight loss. She had never passed dark or red urine. She never had sensitivity of the skin to sunlight, blisters, pigmentation or scars of the skin. No psychiatric symptoms were elicited from the patient or her family. She never had localized weakness, paresthesias, pains in the back or extremities, or convulsions. No history of chills, fever or hypertension was obtained. The routine systemic review was otherwise not remarkable.

Past Medical History: She had had no serious illnesses, injuries, or operations. She had taken no drugs or used any chemicals other than household cleansers. She had given birth

to four children all of whom were living and well.

Physical Examination: Temperature 98°, Pulse 104, Respirations 28, Blood Pressure 130/75.

The patient was a well developed, well-nourished, middle-aged negro woman weighing approximately 130 pounds with an apparently normal weight/height ratio. She was in acute distress and complained of unbearable abdominal pain. She cried out with pain every three to five minutes. She was alert and able to answer questions very well. The skin and subcutaneum were normal. There was no cyanosis present in the mucous membranes or elsewhere. The lymph glands were normal. The head, eyes, ears, nose and throat were normal. Examination of the heart revealed a normal size, heart sounds, and rhythm. The lungs were normal to percussion and auscultation. The abdomen was distended. The umbilicus was three finger-breadths above the xiphoid process with the patient in the supine position. The abdomen was tympanitic but no fluid levels were detected. There was only minimal generalized tenderness. No rigidity, rebound tenderness or masses were present. Peristaltic sounds were present (but not high pitched) at the height of the pains but absent otherwise. The rectal examination was normal and no stool was found in the ampulla. The vaginal examination revealed a normal menstrual discharge, and a normal cervix, uterus and adnexae. The gross neurological examination, including cranial nerves, was normal.

The provisional diagnosis was acute intestinal obstruction.

Clinical Course: She was given morphine gr. 1/4 intramuscularly with some relief of her pain. A flat and lateral decubitus x-ray examination was obtained and this was reported: "There is considerable gas in both the large and small bowel, predominately in the large bowel with the large bowel being dilated down to the mid-sigmoid. This evidently represents a large bowel obstruction most likely in the area of the sigmoid colon. I do not see any evidence of any free intraperitoneal air. Impression: Large bowel obstruction in the area of the sigmoid colon." Figure (1).

The patient voided 200cc of urine one hour after admission. One of us (J.H.L.) saw the



Figure 1.

dark urine and made a diagnosis of porphyria. This finding resulted in an abrupt change in evaluation of the case.

Laboratory findings were as follows: R.B.C. 5.70M., Hematocrit 53%, Hemoglobin 18.65 grams%, W.B.C. 13,900, Segs 89, lymphocytes 11.

Urinalysis: color: amber-black, clear, Reaction: acid, albumin trace, Sugar: negative, W.B.C. O, R.B.C. O, Ep. cells O, casts O. Uroporphyrin-positive, Porphobilinogen: positive, Coproporphyrin: negative.

Continuous gastroduodenal suction produced a small amount of gastric juice. Approximately 1500 c.c. of 5% glucose in saline was administered intravenously during a period of 4 hours. An enema was productive of poor results. She received 400,000 units of penicillin and 0.5 grams of streptomycin intramuscularly.

Approximately three hours after admission the patient complained of air hunger and of distention of the abdomen causing difficulty in breathing. The blood pressure was 70/60, pulse 120, and respirations 36-44. No cyanosis was visible. She was put in an oxygen tent in Trendelenberg position. Four hours after admission she was not improved. The abdomen was more distended. Her sensorium was very clear and her chief complaint was pressure in her abdomen. After discussing the matter with her family the performance of a transverse colos-

tomy under local anesthesia was decided upon despite the established diagnosis of acute porphyria. This was performed without difficulty. An extremely distended colon having the "wet paper bag" appearance was evacuated of much gas. The small bowel was distended to a moderate degree. The stomach was not distended. There was no evidence of peritonitis. There was no cyanosis or pallor of any of the tissues. The proximal and distal visible arteries were bright red in color. Evidences of vasospasm were searched for but none were found. The escaping blood was bright red in color and was under an apparently normal pressure. The distal colon, lower abdominal contents and pelvic organs were not examined in spite of our curiosity. 250 mgm. of neomycin in 10cc. of saline was given intracolonically and intraperitoneally. The distension of the abdomen was greatly reduced. The patient's general condition was not improved. Medical consultation was obtained, confirming the diagnosis of acute porphyria and suggesting a grave prognosis. Postoperatively she received Neosynephrine®, Dextran and Solucortef® 100mgm. intravenously and oxygen via tent with no improvement in her general condition. She died approximately 11 hours after admission. No cyanosis was evident at any time during the course of her illness.

Summary and Comment: Apparently the patient, within two or three hours after admission, was dying of cellular respiratory failure. In retrospect, we were unsure of the situation: (1) Whether or not an intestinal obstruction due to colonic tumor, internal hernia or adhesive bands, primary volvulus or intussussception, or a dyskinetic obstruction secondary to acute porphyria was present. (2) Whether or not a surgical decompression of the greatly distended colon would be helpful to the patient. A closed loop obstruction such as volvulus probably was not present in view of the X-ray findings. The diagnosis of internal hernia or obstruction by means of adhesive bands had little support from the history. The idea of giving primary emphasis to an obstruction such as that due to a colonic tumor as being responsible chiefly for the patient's clinical manifestations and assigning acute porphyria to a secondary role was considered. This idea was abandoned because uncomplicated colonic obstruction seldom produces such a fulminating situation. Approximately 12 hours had elapsed from the onset of symptoms to the onset of marked and rapidly progressive deterioration of the patient. Perhaps a surgical decompression should be done always in such a case but it should be done somewhat earlier in the course of the disease. The possible benefit should be weighed against the morbidity and mortality of such a maneuver in a patient whose fundamental metabolism is severely disturbed and, currently, largely does not admit of correction.

Summary and Conclusions

1. A case of intermittent acute porphyria is presented.

2. We wish to emphasize the interesting problems of surgical disease secondary to acute porphyria, latency, porphyrinuria, and the diagnosis of porphyria masking surgical disease and wrongly diagnosed surgical disease causing acute porphyria to be overlooked.

3. The disease can be characterized by a catastrophic interruption of fundamental metabolism and it can be fulminating and very dangerous.

4. The assessment of the importance of finding the pigments in the urine may be expensive of judgment.

5. It is hoped that more information and discovery for the guidance of management will be documented.

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Abruptio Placenta*

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Abruptio placenta is one of the more serious complications of pregnancy because of the high fetal wastage and maternal complications such as fibrinogenopenia and acute renal failure.

THE frequency with which one encounters this serious complication varies somewhat with the area in which he practices. In the Southeast, where there remains a rather high incidence of toxemia and hypertension, the incidence of abruptio is also found to be relatively high. It has been said that significant degrees of abruptio are found once in every one hundred deliveries. The seriousness of this complication lies not only in the frequency with which it is encountered but also in its detrimental effects on both the fetus and mother. Fetal wastage in this condition varies from 20 per cent in the milder degrees of separation up to 100 per cent in severe and complete placental separation. Infants born alive may have suffered anoxia sufficient to impair development. The maternal threat lies not only in the initial episodes of blood loss and shock but also perhaps more seriously in the frequency of such serious complications as fibrinogenopenia and acute renal failure. The incidence of fibrinogenopenia among patients with abruptio placenta has been estimated to be as high as 10 per cent.[2]

Etiology

The etiology of abruptio placenta is related to maternal vascular damage in at least 80 per cent of cases. This may be acute toxemia, chronic hypertensive vascular disease or a combination of the two. The remaining 20 per cent is due to increased venous pressure,[3] to trauma, direct or indirect, or to other miscellaneous factors which may not be apparent. Since a majority of these cases result from toxemia, and/or hypertension, one might consider that abruptio is preventable to the degree that these hypertensive disorders can be controlled through adequate prenatal care. I am certain that efforts along this line will lead to a significant reduction in the incidence of serious abruptio placenta. However, it will not be possible to eliminate this obstetric complication since we all have seen patients whose blood pressures were well controlled, only, at the time of delivery with abruptio placenta, to find a severely infarcted placenta with indisputable evidence of vascular damage. Anyone practicing obstetrics, regardless of his location, must be prepared with the knowledge and armamentarium to manage abruptio placenta and any or all of its concomitant complications.

Diagnosis

The diagnosis of abruptio placenta is usually made on clinical evidence. The patients may be seized with a severe sharp, constant pain in the abdomen. Approximately 80 per cent show evidence of external bleeding, the remaining 20 per cent have retroplacental bleeding that has not found its way to the outside. The uterus will usually be tense and somewhat tender, and the fetal heart tones may or may not have disappeared. In instances of concealed hemorrhage, the patient may be admitted in shock with the uterine size out of proportion to the stated stage of gestation. Progressive enlarge-

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ment of the uterus within a few minutes of observation may be apparent.

Management

For purposes of discussion, one might classify patients with abruptio placenta according to severity into three categories. First, those patients with only a small amount of blood loss and no uterine tetany and no evidence of maternal shock or concealed hemorrhage. Second, those with more severe blood loss and/or shock and uterine tetany but with a living fetus. Third, those with severe blood loss/or shock with uterine tetany and a dead fetus.

In all patients with a diagnosis of abruptio placenta, regardless of the severity, certain measures should be taken. Blood should be drawn immediately upon admission for a hematocrit, clotting time, and type and cross match. We prefer the clotting time as a means of detecting and following hypofibrinogenemia.[1] Approximately 5 cubic centimeters of venous blood are placed in a clean test tube and observed at room temperature. The time at which the clot appears is recorded. The failure of this blood to clot within 30 minutes or the formation of a weak clot with subsequent dissolution is evidence that the circulating fibrinogen is at a critical level. A normal clot remains stable, retracts well, holds red cells, and can be lifted out of the tube without disintegrating. If a clot forms but breaks up rapidly this may mean excess fibrinolysin. We depend upon this test to follow the clotting mechanism and repeat it every 30 minutes during labor or delivery and every four hours for the first postpartum day. The tubes are marked and kept at the patient's bedside so that her response to therapy can be noted.

Once a diagnosis of abruptio placenta is made, regardless of the severity, the membranes should be ruptured as soon as feasible. It has been shown that the increased intrauterine pressure is of prime importance in forcing thromboplastin and similar substances into the maternal venous sinuses. This initiates the widespread microscopic intravascular clotting and thus depletes the body fibrinogen. Amniotomy will relieve this intrauterine pressure and it should be done regardless of the status of the cervix or the type of labor present. Fortunately, most patients with abruptio placenta will begin labor autonomously and deliver within a short period of time. The amniotomy usually serves to augment this labor. These usually offer no problem and if the patient is progressing in labor one should only follow and replace blood loss, and follow the clotting time, correcting it as indicated. If however, labor does not ensue within an hour after the amniotomy, and the cervix has remained closed in the presence of a living fetus, a Cesarean section is probably the treatment of choice. This is especially true when the seriousness of the abruptio has been sufficient to produce maternal shock, uterine tetany, and large amounts of blood loss. Anything short of this, under these circumstances, would further jeopardize an infant whose life is already in serious danger. A clotting time done prior to the surgery will insure a good clotting mechanism and one must only replace blood loss and maintain an adequate blood volume to expect a good prognosis. If the abruptio is not considered too serious and the cervix is favorable, a dilute oxytocin intravenous drip as described below might be used to establish labor.

Cesarean Section

In the presence of a dead fetus, even with a complete abruptio placenta, it is possible to temporize for a reasonable period of time in the interest of conservatism without jeopardizing the mother. The hesitancy to do a Cesarean section in the presence of dead fetus is indigenous to all obstetric teaching. Thus, the innovation of the use of intravenous oxytocin to initiate labor in these patients was a welcomed adjunct. If the clotting mechanism is normal and the patient has not shown some progress in labor within one hour after the membranes have been ruptured, a dilute oxytocin drip, using one-half cubic centimeter of oxytocin per 1000 cc of 5 per cent glucose in distilled water is begun intravenously. First, a plain infusion of 5 per cent glucose in distilled water is started without oxytocin and after this has been regulated the infusion containing oxytocin is started at 10 drops per minute. The frequency, intensity, and duration of contractions are carefully noted and the rate of flow of oxytocic solution adjusted to maintain optimal labor. We have found, to our surprise, that rhythmical uterine contractions can be established even in patients with uterine tetany. It may be difficult to detect variations in uterine tone with uterine

tetany present, but by close observation contractions will be noted and there will be progression in cervical dilatation. The tetanic uterus has not been more likely to rupture with oxytocin. There has been no increase in serious hemorrhage and the incidence of fibrinogenopenia has not been increased. Close observation of any patient receiving intravenous oxytocin is important and this is especially true in patients with severe abruptio placenta. By the use of intravenous oxytocin we have been able to reduce the incidence of Cesarean section in abruptio placenta with a dead fetus by approximately 75 per cent.[1] There remain a few patients in whom Cesarean sections are necessary. This is true when progress in cervical dilatation and effacement is not sufficient to warrant continuing oxytocin drip after a four-hour period. In patients with continuing severe blood loss it may be necessary to do Cesarean sections. We do not say that one should never do a section for abruptio placenta with a dead fetus but only that it is rarely necessary.

Complications

The recognition of fibrinogenopenia and the availability of fibrinogen for administration has reduced considerably the maternal mortality in severe abruptio. It has been only within the past six to eight years that we have recognized this entity. Prior to this, severe uncontrollable bleeding occurred but this was thought in most instances to be due to poor contractility of the myometrium. The so-called Couvelaire uterus with its subserosal extravasations of blood does not contract normally. However, it is now known that this extravasated blood, as well as severe blood loss from the uterus, is due to clotting deficiencies. Prior to the recognition of fibrinogenopenia as an entity, it was not unusual for these patients to be subjected to postpartum hysterectomies for blood loss in the face of severe degrees of shock and exsanguination. It is now known that hysterectomy is in most instances unnecessary. The hemorrhage can be controlled and the uterus, when inspected several months later, will show no evidence of the previously extravasated blood. When there is abnormal bleeding and evidence of fibrinogen deficiency by failure of blood to coagulate in the test tube, fibrinogen must be administered. One cannot replace fibrinogen with blood bank blood. Blood transfusions are important to replace blood volume but when fibrinogenopenia exists, fibrinogen administration is necessary. This is usually given intravenously in 2 gram increments depending upon the severity of the clotting deficiency. It is seldom necessary to give more than six grams of fibrinogen to any one patient. The response to adequate amounts of fibrinogen is usually very dramatic. Hysterectomy or Cesarean section in the face of clotting deficiency is exceedingly dangerous and when the clotting mechanism has been restored to normal it is usually unnecessary. There are two reasons why fibrinogen should be used only when indicated. First, it is an expensive medication and second, it is accompanied by an incidence of serum hepatitis reported to be as high as 20 per cent.[4]

Acute renal failure has been found to accompany abruptio placenta in a number of cases. This usually results from renal tubular necrosis as a result of prolonged maternal shock. Close attention to blood replacement and the treatment of shock usually is sufficient safeguard against the development of acute renal failure. It is not within the scope of this paper to discuss the detailed management of acute renal failure.

Illustrative Case

The following case report is illustrative of our routine management of abruptio placenta.

R. L. L., a 16 year old primigravida, was admitted to the delivery suite on February 27, 1959 complaining of low abdominal pain.

Present Illness: She was approximately seven and one half months pregnant and had had no prenatal care. Pedal edema and frequent headaches had been present for two weeks prior to admission. She had had sudden abdominal pain approximately 18 hours prior to admission and no fetal movement had been noted since that time. At the time of admission, the abdominal pain was more or less constant and for the most part in the suprapubic area although there was some generalized abdominal pain.

Physical examination on admission revealed a well developed, well nourished, colored female with a blood pressure of 146/110 and a pulse of 84. Her uterus was term size, tender, tense, and in a state of tetany. There was a two plus pitting edema of the lower extremities. Fundoscopic examination revealed normal eye-

grounds. On rectal examination the cervix was 2 cm. dilated, 60 per cent effaced, while the fetus was in a cephalic presentation of a —2 station.

Laboratory Studies: Her initial laboratory work revealed a four plus proteinuria, a microscopic hematuria with three to five granular casts present per high powered field. The hematocrit was 22 volumes per cent, the sickle cell preparation was negative. A Fibrindex® test was reported as subnormal. Blood was drawn immediately for type and cross match and a clotting time. The clotting time revealed no clot formation after 30 minutes of observation.

Course in Hospital: The patient was moved immediately to the operating room where 500 cc. of whole blood was begun as she was being prepared for vaginal examination. The vaginal examination revealed a soft cervix, 3 cm. dilated, 60 per cent effaced, the fetus was in a cephalic presentation at —2 station and the membranes were intact. After the pelvic measurements were determined to be adequate, the membranes were ruptured and approximately 400 cc. of blood stained amniotic fluid was obtained. No gross bleeding was noted at any time during this procedure. The clinical diagnoses at this time were severe preeclampsia with abruptio placenta, intrauterine death and hypofibrinogenemia. Following the vaginal examination and amniotomy, the patient was placed in the labor room where over the next two hour period she was observed for the onset of spontaneous labor. During this period of time, she received 500 cc. of whole blood and 2 grams of fibrinogen intravenously. She was sedated with 75 mg. of meperidine hydrochloride (Demerol®) intravenously and 3 3/4 grains Amytal® Sodium intramuscularly. Blood was drawn periodically for rechecks on the clotting time. At the end of this two hours, labor had not begun satisfactorily and 1000 cc. of 5 per cent glucose in distilled water containing 0.5 cc. of Syntocinon® (synthetic oxytocin) was begun intravenously at approximately 20 drops per minute. The blood pressure was 160/110 and antihypertensive drug therapy was begun. Another unit of blood was given. The clotting time was now three minutes but the clot retraction was poor. Rechecks of the clotting time after this revealed a good clot and an adequate clotting time. At no time had she exhibited evidence of abnormal bleeding from the vagina, other orifices, or needle puncture wounds.

After 2 1/2 hours of Syntocinon stimulation, re-examination revealed the cervix to be 9 cm. dilated, 100 per cent effaced, and the head was now transverse presentation at plus one station. The blood pressure was now 126/90 and the clotting time was normal. Following another hour of Syntocinon stimulation the cervix was completely dilated and effaced, and the fetal head had descended to a plus two station. The caput was visible at the introitus. The patient was moved to the delivery table where under general anesthesia a stillborn infant was delivered by mid-forceps rotation from a right occipitant transverse position. A left mediolateral episiotomy was used. The blood pressure shortly following delivery dropped to 70/40 but responded quickly to 5 mg. methoxamine hydrochloride (Vasoxyl®) given intravenously, and another pint of whole blood. Two hours postpartum the blood pressure was 120/80 and the clotting time was normal. The following morning the hematocrit was 19 vol. % and another pint of blood was given. The clotting time was normal at this time. The patient was discharged home on her sixth postpartum day without further complications.

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Problems In The Management Of Severe Maxillo-Facial Trauma*

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This paper concerns severe facial injury including discussions of severe comminuted fractures and possible complications and repair of defects.

THIS paper concerns severe facial injury with multiple comminuted fractures involving several or all of the maxillo-facial complex of bones. The nose, because of its prominent position, is almost always fractured. The jaw is very often, though not always, involved. Numerous teeth may be lost. Severe, multiple lacerations may exist. Severe edema often follows quickly. Very often there will be considerable interstitial hemorrhage of the facial and oral tissues. Hemorrhage from the sinuses and nose may be pronounced.

General Discussion

The severity of these injuries is such that restoration of the pre-traumatic facial contours may not always be possible. While miracles may result from one carefully executed surgical procedure, it may often require multiple procedures over many months. Infection is especially likely to occur in such severely traumatized tissues. Bone or dermal fat grafts may be required to restore cosmetically acceptable features. Avulsion of tissue may require local rotating or sliding pedical skin grafts or distant pedical skin grafts. Free composite ear grafts may sometimes be needed to restore a nasal ala. Sometimes thick split skin grafts may be required to restore deeply abraded areas of the face.

While prompt surgical restoration is desirable, certain problems take precedence. Hemorrhage must be controlled promptly. Tracheotomy is always required. Evaluation of the patient for severe head injury is mandatory. Transfusions may be required. Tetanus booster injections or tetanus antitoxin are required.

It is wise in most such cases to suture the lacerations and observe the patient. Postponement of surgery up to two weeks or even a month will still permit satisfactory reduction. Such long periods should be avoided, however, unless essential to the welfare of the patient.

The conscientious physician seeks knowledge of the reasons for failure to achieve the best possible end results. Understanding the causes of such failure inevitably results in the evolution of surgical techniques with a more favorable outcome. A knowledge of the potential pitfalls and limitations of a given procedure will lead to a better plan for surgical restoration. The family and the patient may be better prepared for the probable outcome of restorative surgery. Reassurance based on a sound knowledge of restorative techniques will help the physician carry the patient through periods of emotional crisis.

Avoidance of Infection

Infection is related to edema, interstitial hemorrhage and associated tissue trauma. In spite of careful aseptic technique, infection of incisional sites for the open reduction and wiring of fractures is prone to occur. Infection is often severe and hard to control. Open reduction and wiring cannot always be avoided, but it should be kept to a minimum. Elevation of the maxillo-facial complex and trans-antral

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fixation with a Steinman pin will successfully restore a high percentage of cases. When further reduction is required, antral packing via the sub-labial approach, combined with antral windows, will diminish further the need for external incisions. A few will require open reduction and wiring of a fronto-zygomatic suture-fracture or an infra-orbital fracture. Any associated nasal fracture must be reduced and the septum restored to the midline before the Steinman pin is passed. If this is not done, adequate reduction of the nasal fracture may be prevented by the Steinman pin. Wiring of the teeth and interdental fixation of the teeth in occlusion must be done even when no jaw fracture exists. Except when the jaw fracture is very unstable, proper occlusion combined with the pull of the jaw muscles tends to remold the face to its previous contours.

Severe Comminution

In severely comminuted fractures it is especially important that the injury be carefully evaluated. No single method of evaluating the extent of injury is adequate. A history of the angle and speed of impact will suggest the search for certain skeletal injuries. Careful external and intra-oral palpation will reveal the presence and degree of injury with reasonable accuracy. X-rays may confirm many suspected fractures and will often reveal some unsuspected injury. They will also give some indication of the degree of displacement and the degree of comminution of fractured bones.

Steinman pin fixation of the maxillae will seldom be adequate in this group because of the marked mobility of the fracture complex. If the jaw fracture is severe, establishment of occlusion will be most difficult. Dental occlusion will be unstable. It will be ineffective in remolding the facial contours. Blow-out fractures of the orbital floor are probable.

Complications

The possible end results of a failure to fully appreciate these possibilities include the following complications:

1. *Permanent diplopia:*

   Incomplete reduction of an infra-orbital fracture and failure to correct a blow-out fracture of the orbital floor will result in chonic diplopia. If there is serious doubt about the integrity of the orbital floor, packing of the antrum should be done to avoid late diplopia. If there is severe comminution, packing should be done with extreme care. It is possible to cause pressure on the optic nerve if the optic foramen is fractured.

2. *Permanent Malocclusion:*

   This results from a failure to appreciate the degree of instability of the fracture complex. It may result because too many teeth are absent or were lost to permit a satisfactory restoration of occlusion.

   Stable occlusion may require open reduction and wiring of jaw fractures, especially when there is associated severe dental trauma or when many teeth are absent. Even though one may be adept in the wiring and fixation of teeth, it is wise medico-legally to get a dental opinion. This is especially true when multiple teeth may have to be sacrificed because of damage. With the help of a dentist or oral surgeon special dental splints may be made which will improve the prognosis by giving a better dental foundation. If the dentures are present and intact they may also serve the same purpose.

3. *Chronic Temporo-Mandibular Joint Pain and Dysfunction:*

   This is related to the foregoing. Adequate reduction of the jaw fracture and the use of techniques which re-establish a stable occlusion will prevent this complication in most cases.

4. *Chronic Mechanical Trismus:*

   Trismus of this sort usually results from incomplete reduction of the zygoma and resultant impingement on the coronoid process of the ramus of the mandible. It may result from a late fibrotic retraction of a severely comminuted maxillo-zygomatic fracture.

5. *Chronic Facial Deformity:*

   Deformity may be due to depression of one maxilla. Mild degrees may have no significant effect.

   A serious deformity is the "horse face" deformity due to falling and retrusion of the maxillae. There is an associated elongation of the nose with loss of projection. When the mandible is fractured, retrusion of the mandible tends to accentuate the deformity.

The "dish face" deformity is equally unsightly. It is the result of failure to re-establish the forward projection of both maxillae.

6. *Miscellaneous Complications:*

These are not necessarily related to surgical technique. Diplopia and cycloplegia may occur as a result of oculomotor nerve injury related to trauma. The nerve tends to regenerate gradually.

One or both lacrimal ducts may become obstructed because of the severity of injury. They may respond to dilatation but ultimately dacryo-cysto-rhinostomy will be required.

Because of the possibility of recurrent sinus infection I feel antral windows should be done when antral packing is required. Chronic septal deviation, septal perforations and multiple severe intranasal adhesions, besides contributing to the possibility of chronic infection, will cause chronic nasal obstruction.

Great care is essential if both a cosmetic and functional restoration of the nose is to result. Comminution of the maxillo-facial complex may be so severe that even though a good initial maxillo-facial restoration is achieved there may be secondary fibrotic retraction of the maxilla. Iliac bone grafting may be indicated. Iliac bone may be required to restore a saddle nose. Minor, but significant cosmetic depressions are more easily restored with dermal fat grafts. These should be fifty per cent larger than the defect to allow for shrinkage.

Technique of Reduction of the Severely Comminuted Maxillo-Facial Fracture

In this type of injury the technique of Dr. Straith, of the Straith Clinic, is more likely to result in a favorable outcome. This is based on wiring of the teeth and elastic fixation of the teeth in occlusion. Suspension wires which are anchored to the upper dental wires or arch bars are passed deep to the zygomatic arches. Through incisions at the lateral orbital margins the zygomatic process of each frontal bone is drilled. Since the frontozygomatic suture is very often fractured, the frontal process of each zygoma is also drilled to permit wire fixation of this suture fracture. The suspension wires are then passed through the holes in the frontal bone and pulled tight. They are twisted to maintain their position. Packing of the antra with or without open reduction and wiring of the infra-orbital margins may be required.

Repair Of Tissue Defects

The repair of tissue defects is a subject too large to cover in the available space. A knowledge of all the various techniques and their limitations is essential. The technique used may greatly shorten or lengthen the period of restoration. Since gainful employment is often dependent upon full recovery, the method used is important economically.

Concluding Remarks

Repeated encounters with the patients having a severely injured face tends to humble one's ego. The need of selecting techniques suitable to the type and severity of injury eliminates the likelihood of a universally applicable method. This imposes great responsibility on the physician planning the repair. One soon learns to prepare the patient for less than may be accomplished. God still makes the best noses and faces. We can only aspire.

Adenocarcinoma of the Rectum With Metastases to a Phalanx; A Case Report

John Hummel, M.D., and Ralph M. Scott, M.D.*

METASTATIC lesions involving the hands are extremely rare with a total of only 34 cases having been reported. Bronchogenic carcinoma is the most frequent offender, representing 19 of these 34 cases.[1-22] Only one case is recorded as secondary to adenocarcinoma of the rectum and the following, representing a second such instance, seems to merit a brief report.[14]

Case Report

A 52 year old white female had an abdomino-perineal resection and partial removal of the vagina for adenocarcinoma of the rectum in February, 1959. Six months after surgery she was treated in the Radio-therapy Department for incisional implants in the perineal region with an excellent response.

After this treatment she was asymptomatic until October, 1960 when she developed pain and swelling of the proximal phalanx of the third finger of the left hand. This was progressive until she was admitted in December, 1960 at which time a roentgenogram of the hand demonstrated irregularity of the periosteum and mottled destructive changes in this phalanx compatible with metastatic disease (Fig. 1). X-ray examination of the chest at the same time showed multiple parenchymal and hilar lesions (Fig. 2). A biopsy was performed and reported as metastatic adenocarcinoma (Fig. 3).

A palliative tumor dose of approximately 2500 rads was given to the bone lesion in six days with excellent symptomatic relief. Because of pleuritic pain in the right posterior chest this region was also treated with some relief of pain being achieved, but only minimal regression of the underlying lung lesions.



Figure 1. Roentgenogram of the left hand showing destructive lesions in the proximal phalanx of the middle finger.

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Figure 2. Roentgenograms of the chest showing the multiple pulmonary metastases.



Figure 3. Photomicrograph of the biopsy specimen from the phalanx showing metastatic adenocarcinoma.

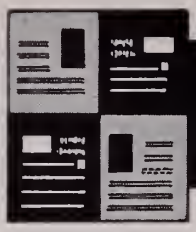
More numerous lung and mediastinal lesions rapidly appeared and the patient expired on March 3, 1961. Post-mortem examination revealed additional metastatic lesions in the pancreas and confirmed the nature of the pulmonary disease.

Discussion

The most frequent source of metastatic disease involving the hands is bronchogenic carcinoma, this representing over one-half of the reported cases. A case representing spread from adenocarcinoma of the rectum is presented, this being the second such case reported. In view of the disseminated pulmonary metastases present in this case it seems reasonable to presume that these occurred first and served as a focus of spread to the phalanx.

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SPECIAL ARTICLES



Facts and Fiction of Medical Care*

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THEY say, you doctors make too much money. The young lady in Cincinnati said that this too is a reason for the high cost of medical care. I told her well, that too is "approximately correct." You know, we have a funny way of talking about doctors' incomes. I have a good friend who flies a jet airplane and makes $20,000 a year. He works an average of 18 days a month. He has a special business on the side in Coral Gables because he has so much time at home. People often talk about one of his neighbors, a doctor, who collects $40,000 a year and they say boy, that doctor is really loaded. What they forget is that a modern doctor is of necessity a businessman. In this scientific jet-age of medicine, he has to pay his rent, pay his phone bill, lights, insurance, nurses, technicians, drugs, equipment, take care of post-graduate studies, buy his journals and all of the rest, and the doctor who collects $40,000 a year doesn't begin to have as much take-home pay as the airline pilot who gets $18,000 or $20,000.

They talk about one neighbor in terms of gross and the other in terms of net and you housewives know there is quite a difference.

A few months ago a man by the name of Tucker, I think it is Ray Tucker, of the American Socialist Party wrote an article called 'The Case for Socialized Medicine'. In this article he points out that if the average doctor in the City of New York were paid the wages of a bricklayer, with time and a half for overtime and double time for nights and Sundays, he would make a whole lot more money as a bricklayer than he does as a doctor.

When you realize, and when you think about your own family doctor, who works six or seven days a week, frequently at night, and when you add it all up and you find out what it costs him to operate, you will also find out why it is that he seems to be working a good deal of the time, and also why his income is greater perhaps. It is not by virtue of taking advantage of the American people. It is by virtue of getting up early and working late.

I'm not defending the unconscionable members of our profession who take advantage of people. I'm talking about the great masses of the American physicians who are honest with you and honest with their profession, just as the great masses of the American people, no matter what their line of endeavor, are honest and try to do a good day's work for a reasonable and an honest day's pay. Just as you may find some doctors who will take advantage of people, so you will find lawyers and architects and engineers, and I've even heard rumors that some repair people that fix your television or radio, don't always do the things that they should.

Most People Are Honest

But by and large, most people are honest, and in our honesty let's not point a finger at all because a few fall short of what they should; and because a few are afflicted with the things we inherited from the time of the Garden of Eden.

We know medicine is costly. It's costly to bring it to you. It's costly to run our offices with all of the equipment and the things we have to do, but we put forth every effort to do it, because you are the American people who want jet-age medicine. It's going to continue to cost, and if anything, it is going to cost more, not less. It is going to cost more because almost daily we have new ideas, new ways to do things, and the more complicated and the more difficult they become, the more people we have to hire to help do it.

So, medicine isn't going to become cheaper. It is

This is the second half of an address given by Doctor Annis at the close of the 1961 KSMA Annual Meeting, Thursday, September 21. The article begins on page 57 of the January Journal.

going to become more costly, but it is also going to continue to prolong the lives of Americans and this is what we are devoted to: to constantly improve the art and the science of medicine and protect the public health.

But, how are we going to pay for this costly jet-age medicine? To the great majority of the American people we say, let us use the great insurance industry which has helped so much, in helping most of us take care of the problems of medical care. The growth of the health insurance phase of the insurance industry has been phenomenal and it reflects one of the most rapid growths in the entire insurance industry. Less than six weeks ago, before the House Ways and Means Committee in Washington, a representative of the insurance industry brought us up to date on the record.

Insurance Policies Improve

The record as of that time was that 134,000,000 Americans carry insurance against hospitalization; 114,000.000 have surgical coverage, 88,000,000 medical coverage and 30,000,000 coverage for major medical expenses, usually those above $500.00. Every year we have more and better coverage, more and better policies. Seven out of ten people who reach the age of 65 can either continue their insurance or convert on a noncancellable plan today, and that wasn't true even a year ago. Three years ago, only three of ten could have done it.

But as the insurance industry has more and more experience and knows more and more about it, they can, and will, do a better job. I'd give a tip to you housewives who have learned how to shop for such things as hats and shoes, and clothes and food. You can shop in the field of insurance, too. You can shop there and find that very often you can find real bargains. Some have found that they can buy Blue Cross and Blue Shield for their basic coverage and use major medical above it. Others have found that various combinations of different plans and different programs suit their needs. But as you shop in the field of insurance, you'll get real bargains for your dollar, especially if you use this medical insurance and not abuse it.

People frequently have a different attitude toward medical insurance than any other kind. Down our way, we have windstorms now and then, sometimes referred to as hurricanes. It is an interesting observation that no matter where they go, if they come out of the south Atlantic, they tag them "Florida" hurricanes. But please don't give us credit for all of them. We have only had one in ten years. The rest of them came pretty close, but not close enough for us to claim as our own.

In Florida most of us carry hurricane insurance and fire insurance. I know people down there, and I have lived in the State 23 years, in Miami 15 and I have never had to use my hurricane insurance, nor my fire insurance and I don't know of anybody who has even complained because they haven't used theirs. And, of course, I don't know anybody who is anxious for somebody else to collect on their life insurance.

Automobile insurance is a good example. If you go home tomorrow and check your budget, you'll find that you spend more money every year for your automobile insurance premium, for collision and property damage and personal liability than you do for your health insurance premium, for your basic coverage and major medical in most instances. But, if your automobile gets sick and needs to be oiled and greased, or needs a new sparkplug, or maybe a new battery, you don't expect insurance to cover it. When the tires wear out, or if you come home, or let's say one of your teenagers comes home at night and bumps a fender, it costs $10.00, $15.00 or $20.00 to get it fixed, yet you don't expect the insurance companies to cover it. Year after year you hope you never use it.

But you know, people come into a doctor's office with a little pigmented mole that is beginning to get the wrong color and the doctor says you ought to have that off. 'How much, Doc?' Oh, $10.00 or $15.00 maybe, including taking out the stitches. 'Well, if I go into the hospital my insurance will cover it.' The doctor says Yes, but if you go into the hospital it will cost $60.00 or $70.00 by the time you pay the hospital room, the operating room, and all of the rest. 'Yeah, but what good is the insurance if you don't use it?'

I had a lady in my office not long ago who had symptoms that suggested she might have had gall bladder disease and I recommended that she have some x-rays. She said, "How much would it cost? . . ." I said, "Oh, I don't know, $20, $25, or $30, depending upon how many x-rays, because sometimes the very first picture tells you the story, and you may not need a lot of them." She said, "Well, if you put me in the hospital my insurance will cover it."

I looked at her record and I saw where her husband was employed and I said, "No. It's an excellent insurance company and they give fine coverage, . . . if you broke a leg on the way home they'd pay for the ambulance, the x-rays, and everything, but this is diagnostic x-ray and it won't cover." And then I gave her the example of an automobile, and I pointed out that when you pay high insurance premiums you are the ones who pay it, the ones who buy the insurance and use it. And if we use it, not abuse it, we'll get more for our money and the costs won't keep going up.

Approves Diagnostic X-Ray

I thought I'd done a real good salesmanship job, but an hour later I found out I hadn't. On the phone was the insurance agent, and I said, "Well now, this is purely diagnostic." He said, "I know, and the insurance shouldn't cover it, but her husband is one of the stewards out at our shop and we have a big contract with this company and in the interest of "our" public relations I'm going to approve her admission to the hospital for diagnostic x-ray." And so it cost $75.00 or $80.00 for what should have cost $20.00 or $30.00. Who pays it? You do when you pay for your insurance.

I'm not trying to say that it is always the patient, that it is often the insurance agent, that it isn't sometimes the doctor who is at fault. I'm not saying that some doctors don't take advantage of insurance and especially major medical insurance and charge more

than they should. But I'll say this: that when they do, you should bring that to the attention of the medical society grievance committee. Any time you feel that a doctor has overcharged you, . . . that's the time to make a complaint, because how can we know if you don't tell us? Once again I'll say that the great majority of the physicians over this country don't take advantage of their patients, and they're not taking advantage of the insurance industry.

And I'll say to you that if you as people who buy insurance, and if your doctors and insurance people and all of the rest of us in America will use insurance like we use our automobile insurance, and our other insurance, and not abuse it, we'll be able to buy the kind of coverage that will enable us to have good coverage to cover this great costly medical care if and when we need it. But we must use it, . . . not abuse it. And for the great majority of the American people this is the answer for their medical needs.

Well, what about those who can't afford it? And let us be more specific and talk about our elderly, because these are they who today are the subject of many programs, some politically inspired, others supported by those seriously desirous of helping take care of our elderly citizens. What about those that can't buy it? Well, let's give you a few figures.

Of the people over 65 in this country—there are nearly 17 million today—8,545,000 carry their own insurance right now; over half. Another two and a quarter million are on old-age assistance. We provide them not only with medical care, but food, clothing, and shelter as well. But there are some other people in the nation who get along very well, and I'm speaking of our elderly citizens, until they are faced with a major illness, and then it is more than their budget can stand.

Medicine long has felt that anyone, old or young, who needs medical care should have it, whether they can afford it or not. There are citizens in our land among our senior citizens in need of medical care who can't afford it. These people we feel are the just responsibility of government when their family and friends, local communities, churches and others don't take care of them. This is the reason that the medical profession has supported the principle of the Kerr-Mills law, passed by the last session of Congress. This law was named after Senator Kerr of Oklahoma, and Representative Mills of Arkansas.

Community Should Determine Need

But it's based on this fundamental principle, that the local community is best able to determine a person's financial need. And they said the one who should determine medical need is the patient's own family doctor, . . . his own local physician, the one at home.

The one to determine their financial need is the local community, because the needs here in this big county and this big city are quite different from the needs out in some of our rural areas. Somebody who has an income of fifteen hundred dollars and lives in Louisville might be totally dependent on the government, . . . but I know farmers who only handle fifteen hundred dollars a year in cold cash, who live better than people in the city who make six and seven thousand dollars a year. Income alone isn't enough to determine need, and only the local community can determine the actual needs of an individual or his family.

And so the Congress came up with this law, called the Kerr-Mills law, . . . leaving to the individual states and the individual communities the determination of how it should be implemented. The law provides that the local doctor will determine medical needs, the local community financial need, and the role of the Federal Government will be limited to grant-in-aid dollars where the Government will have no central control over the medical care or the determination of financial need.

In some of our states this has already been implemented in a beautiful manner, in others they are gaining experience. Some of our states, you may remember, have been doing these things for a number of years. Some of the older states have had more experience, states like Michigan, Massachusetts, and others. We've had programs of this kind in operation in Florida for over six years, and in Tennessee I think for seven years. Your experience here in Kentucky is not as long as ours, . . . you are getting experience. Already, I understand, you have made two changes in your law, and that the implementation is soon to be additionally increased.

The Real Problem

But the real problem is this; locally are the people who can determine the problem, and they are the ones who can best solve it. You can solve it better here in Kentucky, and in Louisville, and in your individual counties than somebody can solve it for you in Washington.

To the extent there are people who need help we think this is right and just. But why should we provide medical care for 16 million people over 65 because 2 or 3 million people need help?

Why are we opposed to the Social Security method of financing medical care for the elderly? There are a number of reasons. But first may I remind you that this is not an extension of Social Security, and those who tell you that it is are using fictional terms. They are being extremely liberal with the truth. A real extension of Social Security would give people more dollars with which to buy their medical care, with which to purchase their own health insurance, after they have shopped around and know which policy they want to buy, to pay their own hospital or doctor or drug bill. This would be an extension of Social Security, . . . giving people more dollars for their medical needs.

How many people do you think who get Social Security now, and who use it to buy food and clothes would give up the money and let the Government provide them with their food, let the Government decide what kind of clothes they would wear, and provide it to them? You see, Social Security gives them dollars, with which to buy the things they want or need, in accordance with their own desires. If they are vegetarians they will buy one thing, and if they like fruits and meats they buy something else. They may want borscht or some other kind of soup. But the point is, they spend it as they please.

But the program that they're talking about, . . . the King-Anderson Bill, as the present bill is called, this is not an extension of Social Security. This is a program that is going to provide a limited type of medical care for our older people, because they are over 65, whether they need it or not. They are not going to let them decide where to go. Oh yes, I know, Secretary Ribicoff and others have appeared on television and they bring a copy of the bill, and in general it says there will be free choice of doctor, and free choice of hospital. And so they say to the people who listen, "See, we've built into this bill safeguards to make sure these older people will pick their own doctor and their own hospital.

The Rest of the Story

But they don't tell the whole story. They don't keep reading on into the same paragraph, because if they did they would read words of this type, ". . . except as otherwise provided." Under the terms "except as otherwise provided" the bill says this: "These facilities will be available only in those hospitals under contract with the Federal Government, under rules and regulations as prescribed by the Secretary of Health, Education and Welfare. The services of physicians and doctors will not be available *except* those in the field of anesthesiology, x-ray, pathology, and physiatry," . . . that's the profession that deals with joints and physiotherapy for older people who have difficulty with muscles, tendons, joints and so forth, . . . "and those interns and residents in teaching hospitals and out-patient diagnostic clinics."

So one place they say there is no involvement of doctors, but under the other provision it involves 50,000 doctors in this country. Only those doctors under contract with the Government by virtue of their hospital connections, and only those who are willing to abide by rules and regulations set up by a non-medical head of the Department of Health, Education and Welfare will specifically provide services under the bill.

As a physician, I am opposed. Most physicians that I know and speak for are opposed to this type of thing because we know it is socialized medicine for this elderly segment of our population. To the extent that government provides for people whether they need it or not; to the extent that the government decides what kind of medical care they are going to have and give them only this kind of care only in those hospitals under contract, this is socialized medicine for this segment of our population. This we believe because it is designed not just to take care of those who need the help of their fellow Americans, but to take care of those rich and poor, merely by virtue of age, and not by virtue of need.

This is one reason, our main reason, for opposition to this measure. But as the father of eight children who are faced with an ever-increasing, growing debt which is being voted by one generation to be paid by the next generation, I have additional reasons to oppose this legislation. It is unfair, it is inequitable. Here is a situation whereby forty percent of the nation's income pays no Social Security tax whatsoever, so when we increase this tax, this forty percent doesn't pay any of the cost of this medical care.

Income from stocks and bonds, oil, rents, incomes over $5,200 won't pay any increased Social Security tax, . . . that means that those under $5,200 are the ones who bear the brunt of the burden. The immediate tax increase of a person today who makes $5,200, . . . they now pay $144.00. The proposal given six weeks ago by Secretary Ribicoff would increase this 17%. They would add another $25 for the employer and the employee, making it $169.00 for each. And this doesn't count the already set increases to go into effect in '63, '67, and '69.

We're having an ever-increasing tax burden placed upon the young people to pay for many of our older people who are well able to take care of themselves, and are willing to do it. They are doing it now and they want to continue.

Here we have a situation where those who work will be taxed, our farmers will be taxed, our workers will be taxed. Who's going to benefit? Initially, none of those who pay the tax, but everybody by virtue of age who is over 65 and eligible for Social Security.

Another Inequity

Another of the inequities in this very definite program, is illustrated by the 20 percent of the people who work in this nation who don't make enough to pay an income tax. They make so little, when they get through with their ordinary deductions in running their families they pay no income tax. And so here's another welfare tax, that we're not putting on many of the rich, but we're putting it on these people who make so little they pay no income tax, but they will be required to pay additional Social Security tax. If this isn't something that's inequitable in the field of taxation, where we're taxing one group of people to get money to pay a welfare program to others, many of whom are well able to take care of themselves. There are 8,545,000 who could drop their insurance and let the working taxpayers pay their bills. As a physician and as a father of a bunch of youngsters, and as an American citizen I think it is wrong to take from people who work and to tax them to pay the bills for many people well able to take care of themselves.

It's so easy to demagogue this problem, It's so easy, and this is the trouble. Most of those in our Congress, . . . most of our Senators, most of our Representatives are busy. They're like most of us doctors, we've been so busy doing our job, taking care of our own affairs that we haven't been busy in the affairs of government. Housewives are busy raising their children and they haven't paid too much attention to what's going on. Men are out doing their various jobs, doing the things that they have to do day in and day out and, we've gotten farther and farther away from our representatives and we don't even know how we feel about things, nor do they.

In early America everybody knew everybody in the small communities, and they elected people who represented their thinking because they knew the barber and the town banker and the lawyer, and the businessman, and the man who ran the general store. And these people made up their town council. But

they knew the people, and the people knew them, and they could quickly contact one another and let them know how they felt about things. And they still do this in rural America. The real strength of this great nation is seen when we get away from our big cities and get to know those who stand on their own feet and do their own work, take care of themselves, rear their own children, and learn what it is to be independent.

Congressmen Are Busy, Too

As we get into our big cities we get farther and farther away from our representatives, and we're too busy to pay attention to what is going on. But we forget this, they're busy too. Up there in the House and in the Senate, they belong to a number of different committees. And let us suppose that your Representative or your Senator is on the very important Military Affairs Committee. In a time when we are dealing with International cutthroats it takes all of their time and their efforts and they haven't got time to listen to these other programs. And then somebody comes along and talks to them, and they talk to you, and they say that we have a real problem in this country of our older people, and what we want to do is just have a little increase in the Social Security tax. We want people to put a little bit aside now so that when they get old it will take care of their medical needs.

They continue that we feel that in this nation of ours the least that a grateful people can do is to take care of its senior citizens. Or as Mr. Reuther said, that we may take care of them during the "Autumn of their lives." Well, you know, all of us want to take care of them. I don't know anybody, doctor or anybody else who wants to see anybody in this nation, old or young, deprived of the benefits of medical care. We don't want to see them starve, we don't want to see them go cold, . . . we'll give them food and clothes and shelter and medical care, anything else they need. But because some need it is no reason to pass laws and have the Government decide that everybody should have a certain type of thing.

These are things that you and I now have to begin to realize, because our own congressmen are often too busy to know the issues that are involved. The only way that we can call their attention sharply to the issues is to let them know that we have suddenly awakened to the fact that either we run our Government or it will run us. Being busy is no excuse for neglecting the responsibilities of citizenship. You and I now must become interested, and as we become interested and look into the problems, then we should let our congressmen and our senators know how we feel. If the ones we have up there don't vote and act in our behalf as we think they should, that's the time to look around for somebody else who will reflect our thinking, and do the thing that we want.

I'm not here to try to give you a "snow-job," I'm not here to try to persuade you to a political line of thinking. It may surprise a lot of you to know that I'm a Democrat. I'm not here to put something over on you, but I am here to suggest some ideas to you so you will make sure that no one else will put something over on you. And that they won't put it over on your Representatives or your Senators because they in turn are too busy doing something else to look into the real issues underlying other problems than those of their particular committees.

It doesn't take long to make a speech in behalf of anybody, and to say that a grateful nation should take care of its senior citizens, . . . of course it should, and we want that it should. All of us want this, but it takes time to analyze the various proposals and to find out what's really behind them.

I wonder why it is that former Representative Forand said that this bill isn't what we want, but once we establish this bill we will have our foot in the door, and then we'll expand it in every direction. On the morning that I debated Senator Humphrey in New York I picked up a copy of New America, the socialistic newspaper, . . . the Socialist party's newspaper, and it said that the "King-Anderson Bill is not enough but it will establish the framework, and once we have established the framework in the Government we will expand it in every direction until every man, woman, and child in America is taken care of under a system of socialized medicine."

Those who have a long-range view, those who have a long-range view of gradualism will try to get to us because they know we are a nation of kind hearts and gentle people, not one of us is going to deny our older citizens of any help that they need. They say we want to take care of our older citizens and they get us nodding our heads, "sure we do," and they'll say this is the way we're going to do it. And we go back to work and they do it, but they don't always do it in a way that is best for America.

Quotes Henry Ford

When I grew up on the East side of Detroit, Henry Ford used to say that the only way we can build a great country is by mass production. He said, "We can build enough automobiles in a month to take care of all the rich people for a couple of years, what we have to do is build automobiles in such quantities and to pay wages high enough that the average worker, when he gets through working paying his taxes for police and fire and school, and all of the rest, still has dollars with which to buy the things he wants and needs, . . . and to buy the automobiles he helped build."

Why is it in this nation of ours with less than six per cent of the world's population, we have produced more of this world's goods, more bathtubs, more iceboxes, more radios, televisions, automobiles and everything else, and more homes for its people than all of the other 94% of the world put together. And in the last 13 years while we're doing all of this, paying our taxes, sending our kids to school, building all of our roads and our schools and everything else we have also given away $84 billion.

But there are men in Washington who say we don't know how to spend our money, and that what we should do is take more money away from the people, . . . after they have earned it but before they get a chance to waste it, . . . and give it back to them in terms of more and better roads, more and better schools, more and better culture. I'm sure that all of us want more and better roads, and more and better

schools, and I suppose a little more culture would do all of us a lot of good. But the difference is they want to make the decision in Washington, not here.

You know, I often think when I read about depressed areas, the pilgrims landed on a depressed area. They had nobody to take care of them. But they came from other lands where government was all-important and the individual wasn't important. They came here and established a government where the individual could worship as he pleased, could work as he pleased, could study and learn a new occupation, could move around freely from one city or one community or one area to the next. He could work hard to take care of himself and his family. All he had to do was recognize the rights of his neighbors, and the opportunities were limitless. But they raised their children to realize that with the opportunities went responsibilities, and that the great future which was offered by America also carried with it the responsibility of working hard, self-reliance, independence, helping one another to grow and to make a great nation, and helping to take care of those who need help.

We think this tradition is still sound. It is under this tradition that American medicine has become great.

And I'd like to close with one quotation from Benjamin Franklin, who answered a heckler one day who said, "Mr, Franklin, where's all this happiness that the constitution guarantees us?" To which Franklin said, "The constitution, my friend, guarantees you the pursuit of happiness, you have to catch up with it yourself."

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville 5, Kentucky.

EDITORIALS

The Doctor and Politics

THIS is a time to pay attention to politics, for politics is pointedly paying attention to us!

Never before was there such a particular urgency for the physician to interest himself in issues and to become involved in political considerations.

There is present a real threat to our livelihood and our professional satisfactions. It is cogent—vital—imperative—that we defeat the concept of medical care through social security.

This can be done by simply informing the public on all details of the King-Anderson Bill, the Kerr-Mills Law and current private health insurance plans.

Propaganda is not needed. Only truth is necessary. Logic and the weight of evidence are squarely on the side of the Kerr-Mills Law and private health insurance as the more just, the more practicable, the more reasonable solution.

The problem is to bring the facts to the public. The television appearances made by Dr. Edward R. Annis helped, but what is needed now is individual talks before local civic groups, PTA's, clubs, etc.

Something like this is happening in Jefferson County. A year ago a "Study Group" was formed among Jefferson County doctors. The purpose—to study this and other issues. These men have now begun to appear before civic groups and bring to them the facts. They do not parrot statements made by Dr. Annis. They do not read phrases from AMA literature. They *do* state the facts on both sides of the issue, allowing their audiences to draw intelligent conclusions based on the truth.

This needs to be done throughout the state. It needs physicians who will take time to become thoroughly informed on the issues. It does not require men gifted in oratory. Any man with a message, who understands his subject well, can convey it to an audience. There are no tricks. There is no fear of a hostile group or of embarrassing questions, because facts cannot be embarrassed.

Physicians interested in forming a study group may contact the Jefferson County Medical Society for sources of material to study, and methods proved useful by this study group.

This is a time to pay attention to politics! Politics is after us!

R. Burke Casper, M.D.

**Reprinted from the January, 1962 issue of the KAGP Journal through the courtesy of the editor.*

Physical Unfitness

PHYSICAL fitness is a measure of the body to perform at peak activity, for prolonged time intervals with maximal efficiency. It is an acquired state, not inherited, and may increase or decrease depending upon the environmental stresses to which it is subjected.

The extreme as to how "fit" one may become is limited by many fixed variables such as body habitus, genetic background, sex, age, and general body health. However, fitness is not solely dependent on fixed variables but also variables that can be controlled such as training, diet, physical activity, and motivation. It is by controlling these variables that one can develop a fit or unfit group.

Since 1956 the lay press in our country has deluged readers with comparative studies of physical fitness of American youth against the physical fitness of Western European youths. To the surprise of many and the chagrin of all, the American group was woefully less fit than its European counterpart, and even more disturbing, a high percentage of American youths were subnormal.

The same physical fitness examination has been given for years to entering freshmen at Yale University, West Point Military Academy, and Compton College in California with the unpleasant finding of an increasing percentage of failures each year. There has been a marked awareness of this problem by the military of this country and those physicians who examine draftees are acutely aware of this problem.

"Physical Unfitness" has approached such alarming proportions that it has prompted both President Eisenhower and now President Kennedy to alert our country to the danger and to make recommendations that would remedy the ills. Recently President Kennedy has suggested 15 minutes per day of vigorous physical activity for all students and has appointed Coach Bud Wilkinson of Oklahoma University as Special Consultant to the President on Youth Fitness. Through these means an immediate crash program has been instituted to stem the progressive deterioration of physical fitness among our people.

The reason for the deteriorating physical state in this country stems from the highly refined technological advancements which have produced such profound cultural and social changes. There is a tremendous impetus of "make a machine to do your work" and success has been so phenomenal that gadgets have been created to eliminate or reduce physical activity in every sphere of our life. We have refined the technique of substituting a machine for a man to an infinite degree with the unpleasant result of falling victim to our own intellectual brilliance.

There seems little question about the physical unfitness of Americans, nor does there seem to be any question that the number of unfit is increasing at an alarming rate each year. The question of importance then is whether unfitness creates a health hazard. There is evidence that a continued hypokinetic state pursued over a long period of time provides a person with the physical stamina to protect himself against only the usual environmental stresses to which he is subjected. However, any sudden spike in activity, or emotional demand, leaves him woefully inadequate to cope with added stress.

The physically unfit experience many unpleasant symptoms when they must cope with added physical stress, among which are muscle pain, joint pain, tachycardia, breathlessness, easy fatiguability and an overwhelming feeling of inadequacy. It is often this sudden realization of inadequacy that creates panic and resultant anxiety.

Physiologically, marked differences exist between the trained and untrained individual. The trained athlete possesses a greater cardiac re-

serve manifested by decreased heart rate, increased stroke volume and cardiac output and increased A-V O_2 difference, plus the capacity to perform at long time intervals without subjective symptoms.

That inadequate exercise is a factor in disease is well documented by the work of Doctors Hans Kraus & Wilhelm Raab who have recently published a summary of this problem in book form "Hypokinetic Disease."

As physicians then, if we can agree that our present technological advances have created an artificial environment that results in physical unfitness, and that unfitness in itself may be a health hazard, then we are obligated to attempt a solution to the problem.

An active interest and reeducation of the medical professions to the problems of unfitness is urgent. It is also necessary to educate parents and teaching personnel that physical work and activity are equally as important to health as immunization, diet, rest, and nutrition. If these groups are convinced of the dangers of physical unfitness, coordinated activity with coaching personnel and civic organizations can result in community projects to assay needs and implement solution on a local level. The alternate to inactivity in this sphere is to sit back and have someone else show the way.

John L. Wolford, M.D.

1962—A Critical Year for Medicine

Annual Interim Meeting

February 22 at Gabe's Restaurant, Owensboro

6 Top-notch Speakers • Discussion Period

Reserve Thursday, February 22, for this Important Conference

ORGANIZATION SECTION

Final Plans for Interim Meeting Feb. 22 Announced

"1962—A Critical Year for Medicine" will be the theme of the KSMA Interim Meeting (formerly the County Society Officers Conference) at Gabe's Restaurant in Owensboro on February 22, according to Gaithel L. Simpson, Greenville, KSMA president.

"Because this year is going to be a crucial one for medicine in the legislative and socio-economic areas, attendance at the meeting is of utmost importance to every physician and particularly to officers of the Association and county society officers throughout the state," he said.

A wide range of subjects will be covered by authorities in their fields from across the nation. The meeting will open with a discussion of "How Private Practice Can Survive" by Carl R. Ackerman, M.D., head of United Medical Service (the country's largest Blue Shield Plan). Following his talk Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association, will delve into little publicized facts of the Kefauver inquisition in a talk entitled, "When is a Fact a Fact?"

"Rumblings along the Potomac" a review of the national legislative scene and a presentation of the AMA's view will be given by Wesley Hall, M.D., Reno, Nevada, a member of the AMA Board of Trustees.

Robert P. Varley, Th.D., a speaker with an inspirational and thought provoking message delivered with a touch of humor, will discuss "Medicine's Mission in a Changing Culture" at the luncheon session.

"Do Doctors Dare Debate?", a thought provoking topic which should spur you into action, is the subject to be covered in the afternoon session by William R. DeMougeot, Ph.D., director of debate and forensics at North Texas State College.

Members of the KSMA Awards and Nominating Committees will meet at the luncheon which is scheduled for 12:30.

AMA Urges All State Societies To Support Blue Shield Plan

The American Medical Association is urging all state medical associations to cooperate with their Blue Shield affiliates in supporting a nationwide Blue Shield program to provide surgical and medical care benefits for all persons over 65. The estimated minimum fee for such coverage would be $3 a month.

The proposed Blue Shield program would provide for services rendered in either hospitals or nursing homes; would pay the full cost of medical-surgical services for a single person over 65 with an annual income of $2,500 or less and for a married couple with annual income of $4,000 or under. Those with incomes above these limits could be subjected to additional charges at the discretion of individual physicians. The plan would cover costs of anesthesia, radiation treatments, X-ray examinations, laboratory tests and pathology services.

The AMA Board of Trustees meeting in January adopted the following statement:

"In December 1958 a policy adopted by the AMA House of Delegates recommended that physicians 'expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income,' and 'that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate.'

"The Board of Trustees believes that a plan proposed by Blue Shield for national coverage of physicians' services for those over 65 under certain income limits conforms with the spirit of this policy. The Board of Trustees recommends that the constituent medical associations take such action as is necessary to cooperate with the proposed Blue Shield Plan and applauds this effort by the Blue Shield."

Eighth Annual Senior Day Scheduled for March 19

Hebbel E. Hoff, M.D., Hambleton professor of physiology at Baylor University College of Medicine, Houston, Tex., will be the featured speaker at the evening session of Senior Day, March 19, when senior medical students at the University of Louisville will be guests of physicians. Senior Day is sponsored by KSMA in cooperation with the U. of L. School of Medicine and the Jefferson County Medical Society.

Individual members of the Jefferson County Society will be hosts to individual members of the senior class at the evening session.

Doctor Hoff was formerly an associate professor of physiology at Yale and professor of physiology at McGill University, Montreal, Canada. He is presently associate editor of the Journal of Neuro-physiology. He is a former Rhodes scholar and received his Ph.D. in neuro-physiology at Oxford and his M.D. at Harvard.

"Professor, Practitioner and Pupil" is the subject

of the address which Doctor Hoff will make at the evening session in the Medical Arts Building, following a social hour and dinner.

Senior Day will get underway with a morning session starting at 12 noon in Rankin Amphitheatre in General Hospital.

The afternoon session will be held at the Medical Arts Building, beginning at 2:30 p.m., and will cover such subjects as: "Bridging the Gap"; "Human Equations in Medicine"; "Practical Economics of Medicine", etc.

The Women's Auxiliary of the Jefferson County Medical Society will be hostesses to wives and sweethearts of the senior medical students. Details for this activity will be announced at a later date.

Carl Cooper, M.D., Bedford, is KSMA chairman of the Senior Day committee. David W. Kinnaird, M.D., Louisville, is Jefferson County chairman.

Attendance Runs High At KSMA Trustee District Meetings

G. L. Simpson, M.D., Greenville, KSMA president, has expressed deep appreciation to the 15 Trustees for their cooperation and support of the program to schedule meetings in all 15 KSMA Trustee Districts during the first 45 days of the new year.

Following approval by the KSMA Board of Trustees at the September 21 meeting of Doctor Simpson's plan to hold these meetings—devoted to the alerting of the membership to its legislative responsibilities—a steering committee was appointed to coordinate the plans, assemble material and work with the Trustees.

"At the time the February issue of our Journal goes to press, more than a third of the scheduled 15 meetings in the districts have been held. The interest in and attendance at these meetings has been considerably above the average. I am most grateful to the Trustees for their cooperation and to the members for their support," Doctor Simpson said.

The Interim Meeting — formerly known as the County Society Officers Conference — to be held February 22 at Gabe's Restaurant in Owensboro, has been scheduled as the climax to this series of meetings held in the districts, Doctor Simpson explained. He urged all county officers and members to attend the Owensboro meeting on Washington's birthday.

30th S. E. Surgical Congress in Louisville March 5-8

More than 75 speakers, including 10 guest speakers, will highlight the thirtieth annual meeting of the Southeastern Surgical Congress at the Brown Hotel in Louisville on March 5, 6, 7, and 8.

Included on the four-day program will be five Kentucky physicians. On the opening day of the meeting Rudolf J. Noer, M.D., Louisville, will be a member of a panel discussing, "Pitfalls in Management of Patients with Multiple Injuries." On Wednesday, March 7, he will present a talk on "Mammary Cancer: The Place of Adjunctive Therapy in Operative Treatment."

Douglas M. Haynes, M.D., Louisville, will discuss "Cesarean Hysterectomy" on Tuesday, March 6. "Double Penis: Report of Case with Surgical Management" will be discussed by J. Andrew Bowen, M.D., Louisville on Wednesday. Also on Wednesday's program will be J. Herman Mahaffey, M.D., and Daniel Mahaffey, M.D., Louisville, with a joint presentation entitled, "Successful Surgical Repair of Abdominal Aortic-Vena Cava Fistula Caused by Rupture of an Arteriosclerotic Aneurysm."

"The Challenge of the Biologic Aspects of Cancer of the Breast" will be discussed by Francis M. Massie, M.D., Lexington, on Thursday, March 8.

A special nurses program is also planned and six Kentucky physicians will participate in that portion of the program which will be held at the same time the surgeons are in session. Following are the physicians and the panels they will participate in: Louis Foltz, M.D., Louisville, "Psychological Aspects of Surgery and Surgical Nursing"; Francis Massie, M.D., Lexington, "Rehabilitation of the Surgical Patient"; J. Duffy Hancock, M.D., and E. H. Baker, M.D., Louisville, "Unusual Occurrences in Operating Rooms"; Alex J. Haller, Jr., M.D., and Daniel Mahaffey, M.D., Louisville, "Open Heart Surgery."

The tentative program was listed on page 67 of the January issue of the KSMA Journal.

Members' Suggestions Solicited for '62 Award Recipients

All KSMA members and county society officers are urged to give thought to deserving recipients of the Association's three top awards—the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award—which will be presented at the 1962 Annual Meeting.

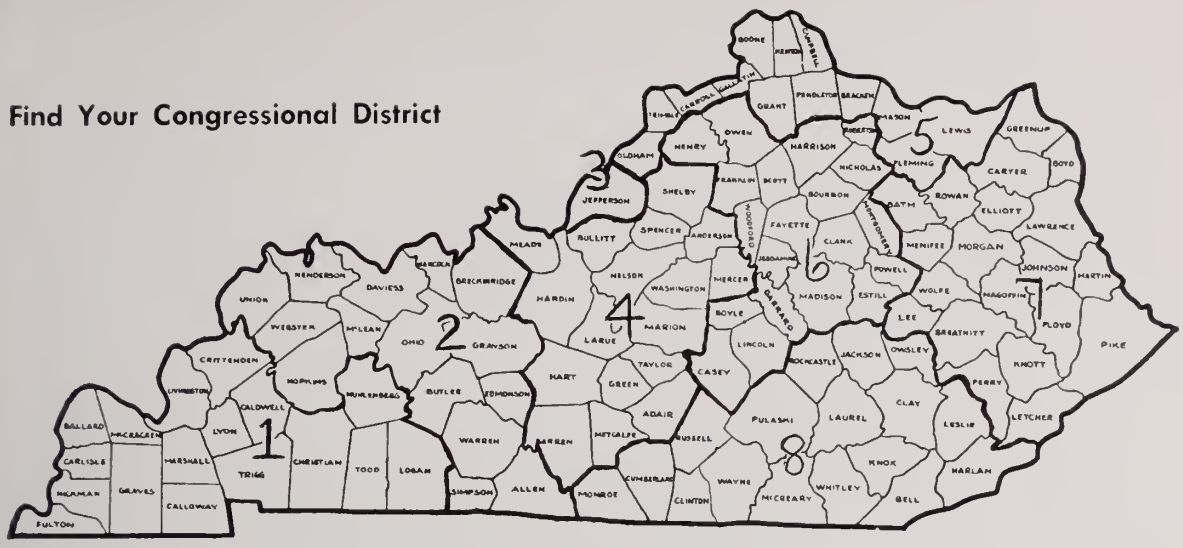
The Awards Committee, headed by William H. Bizot, M.D., Louisville, will meet at the Interim Meeting Luncheon session in Owensboro on February 22 and will welcome any suggestions you may have for awards recipients.

Both the Distinguished Service Medal and the Outstanding General Practitioner Award are given to physicians and the R. Haynes Barr Award is for a lay person making outstanding contributions in the field of public health and medical care. Last year's awards recipients were A. Clayton McCarty, M.D., Louisville, Distinguished Service Award, and Eva Ray Wunderlich, Louisville, R. Haynes Barr Award. The Outstanding General Practitioner Award was not given in 1961.

U. of L. Alumni Elect Officers

The newly elected vice-president and secretary-treasurer of the University of Louisville Medical Alumni were incorrectly named in the January 1962 edition of The Journal. New vice president is Hoyt D. Gardner, M.D., and the new secretary-treasurer is William P. VonderHaar, M.D. Both are Louisville physicians.

J. Thomas Giannini, M.D., Louisville, was re-elected president.



Boundaries of Kentucky's Congressional districts are shown above

KSMA Council on Legislative Activities Urges You to Contact Your Senators and Congressman in Washington on Vital Issues

Legislation which could influence the future of medicine will undoubtedly be on the agenda of the second session of the 87th Congress which convened in January, according to John C. Quertermous, M.D., Murray, KSMA legislative chairman for national affairs.

With the King-Anderson Bill and the Kefauver-Celler Bill under discussion, Doctor Quertermous said it was doubly important this year that every physician make his views known to his Congressman and Senators. In urging all KSMA members to do so, he stressed the fact that 1962 would be a critical year for the profession.

Since you will want to keep in close contact with your Senators and Congressman on these vital issues, the Council on Legislative Activities has prepared the following list for your use. Also listed is the AMA Washington office and your legislative representatives there.

U. S. SENATORS

Name	Home Address	Capitol Address	Telephone
John Sherman Cooper (R)	Somerset	Room 125 Old Senate Office Building	CApitol 4-3121 Extension 2542
Thruston B. Morton (R)	Glenview	Room 437 Old Senate Office Building	CApitol 4-3121 Extension 4343

U. S. REPRESENTATIVES

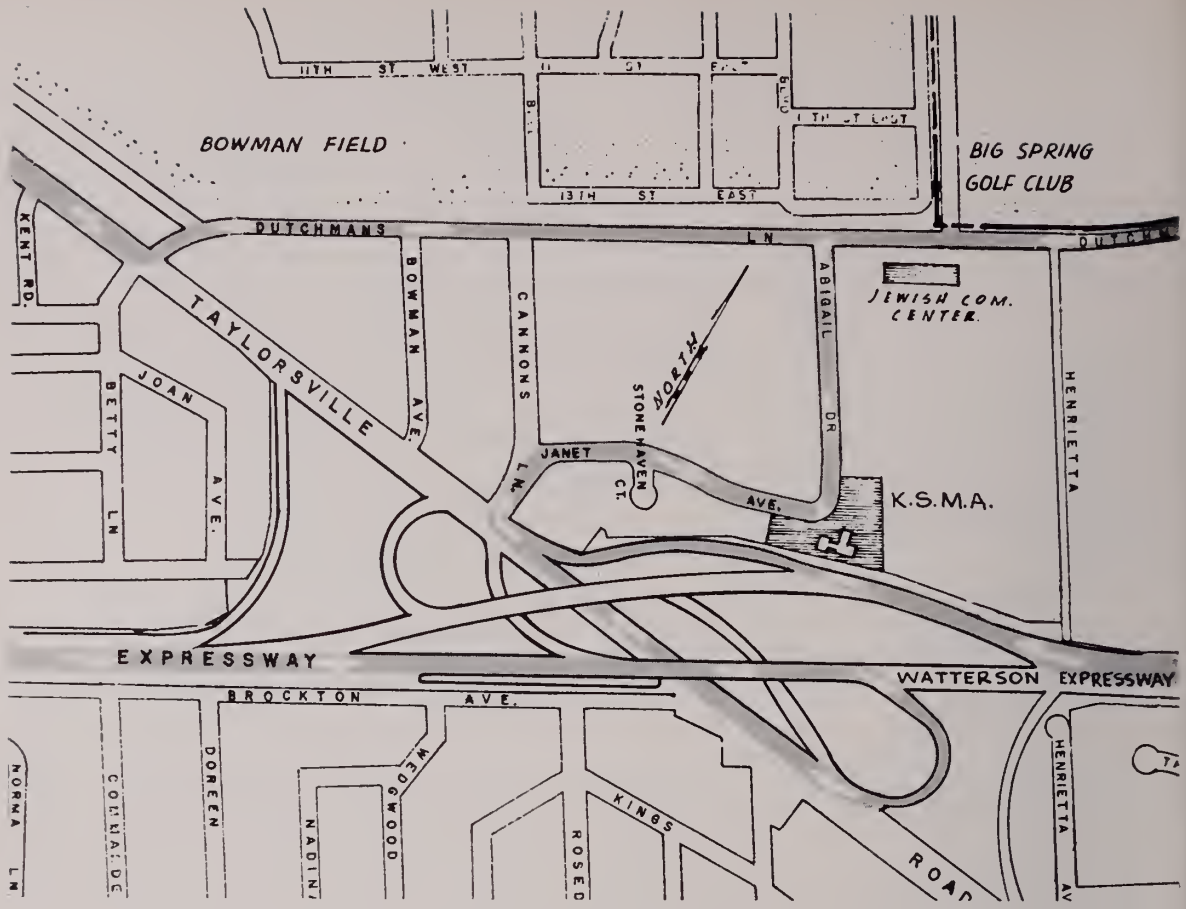
Dist.	Name	Home Address	Capitol Address	Telephone
1	Frank A. Stubblefield (D)	Murray	Room 1228 New House Office Building	CApitol 4-3121 Extension 3115
2	William H. Natcher (D)	Bowling Green	Room 117 Old House Office Building	CApitol 4-3121 Extension 3501
3	Frank W. Burke (D)	Louisville	Room 220 Old House Office Building	CApitol 4-3121 Extension 5406
4	Frank L. Chelf (D)	Lebanon	Room 449 Old House Office Building	CApitol 4-3121 Extension 3465
5	Brent Spence (D)	Fort Thomas	Room 1336 Old House Office Building	CApitol 4-3121 Extension 2305
6	John C. Watts (D)	Nicholasville	Room 1534 Old House Office Building	CApitol 4-3121 Extension 4706
7	Carl D. Perkins (D)	Hindman	Room 1409 New House Office Building	CApitol 4-3121 Extension 4935
8	Eugene E. Siler (R)	Williamsburg	Room 209 Old House Office Building	CApitol 4-3121 Extension 4601

AMA WASHINGTON OFFICE

Manager	Address	Phone
Roy T. Lester, M.D.,	One Farragut Square South	STerling 3-8155

Legislative Representatives

Cecil Dickson — James Foristel



Visitors to the new headquarters building of the Kentucky State Medical Association will find the above map helpful in selecting the best route. Those travelling on the Watterson Expressway should turn onto Taylorsville Road North at Cannon's Lane, then to Janet Avenue and direct to the building. Visitors coming from the Highlands in Louisville or from the St. Matthews area can take Dutchman's Lane to Abigail Drive and approach the office directly from this street.

1962 Annual Meeting Plans Made at Recent Meetings

Several meetings on plans for the 1962 KSMA Annual Meeting on September 18-19-20 have already been held and another is scheduled in the near future, according to Gaithel L. Simpson, M.D., Greenville, chairman of the Council on Scientific Assembly.

The Council on Scientific Assembly met in Louisville on December 6 to make preparations for the coming meeting. Then the program committee, headed by Edmund Pellegrino, M.D., Lexington, met on December 28 to decide on a possible program for the sessions.

Presidents of the 14 specialty groups which hold sessions during the meeting met on January 4. This year the specialty group meetings will be held on Tuesday and Thursday afternoons.

Members of the Council on Scientific Assembly are: Doctor Simpson, chairman; David Cox, M.D., Louisville, vice chairman; Douglas Haynes, M.D., Louisville; Donald Dudderar, M.D., Newport; Edmund Pellegrino, M.D., Lexington; Beverly Towery, M.D., Louisville, and Alex Haller, M.D., Louisville.

Heart Symposium March 28-29 Features Addresses, Panels

The Eighth Annual Symposium on Cardiovascular Diseases, sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine will be held at the Brown Hotel, Louisville, March 28-29.

F. Albert Olash, M.D., Louisville, chairman of the Symposium committee, will preside at the opening session Wednesday morning, March 28. Speakers will include: Jack Crowell, Department of Physiology, University of Mississippi, Jackson, Miss., who will speak on "Shock"; Max Sadove, M.D., head, Division of Anesthesiology, University of Illinois, Chicago, "Cardiovascular Collapse"; Sidney P. Schwartz, M.D., associate clinical professor of medicine, Columbia University, New York, "Heart Block". Following the addresses, Walter S. Coe, M.D., Louisville, president of the Heart Association of Louisville and Jefferson County, will moderate a panel on "Cardiovascular Collapse".

Marc J. Reardon, M.D., Covington, president of the Kentucky Heart Association, will preside over the Wednesday afternoon session, which will open

with the showing of films. Two of the afternoon speakers, whose subjects are open, will be: William Likoff, M.D., director, Cardiovascular Section, Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, and Dwight Harken, M.D., associate clinical professor of surgery, Harvard Medical School, Boston.

"Alveolar Hypoventilation in the Pathogenesis of Cor Pulmonale" will be discussed by Alfred P. Fishman, M.D., associate professor of medicine, Columbia University College of Physicians and Surgeons, New York City. His address will be followed by a discussion period.

Jesse Stuart to Speak

Jesse Stuart, Greenup, Ky., author and Kentucky poet laureate, will address the dinner session on Wednesday.

Thursday, March 29, the morning session will be presided over by Jack Chumley, M.D., Louisville, scientific editor of The Journal of the Kentucky State Medical Association and president-elect of the Heart Association of Louisville and Jefferson County.

At the morning session Jack Whisnant, M.D., assistant professor of neurology, Mayo Clinic, Rochester, Minn., will discuss" Medical and Surgical Treatment of the Incipient Stroke". Another speaker will be E. Stanley Crawford, M.D., associate professor of surgery, Baylor University College of Medicine, Houston, Tex., whose subject is open. "Anticoagulation in the Treatment of Patients with Stroke" will be discussed by Fletcher McDowell, M.D., visiting physician in charge, Cornell Neurological Service, Bellevue Hospital, New York City.

Edmund D. Pellegrino, M.D., professor and chairman of the Department of Medicine, University of Kentucky College of Medicine, Lexington, will be moderator of a panel on "Cerebral Vascular Diseases". Participants will be Doctors Whisnant, Crawford and McDowell.

Towery to Preside

Beverly T. Towery, M.D., professor and chairman, Department of Medicine, University of Louisville School of Medicine, will preside at the Thursday afternoon session. It will open with the showing of films, followed by two addresses: "Auscultation and Phonocardiography" by Aldo A. Luisada, M.D., research professor and head, Division of Cardiovascular Research, Chicago Medical School, and "Auscultation" by J. Scott Butterworth, M.D., president, American Heart Association, and associate professor of medicine, New York University School of Medicine, New York City.

The Symposium will close with a Clinical Pathological Conference moderated by Ira Gore, M.D., chief, Laboratory Services, Veterans Administration Hospital, West Roxbury, Mass. Doctor Gore is also professor of pathology at Boston University Medical School and chief of pathology at Massachusetts Memorial Hospital, Boston. Participating in the panel will be J. Scott Butterworth, M.D., New York City; Joseph P. Holt, M.D., Louisville, and Woodford B. Troutman, M.D., Louisville.

Student AMA

University of Louisville

Shortage of Doctors

Medical care for the populace of our country and for that matter, the entire world, has become of paramount interest in the past few years. It is common knowledge that the number of medical graduates each year is not sufficient to keep up with the growth of the population and this has intensified greatly the problem of proper medical care in the United States. There are many reasons that not enough doctors exist—too few students desiring a medical career, not enough medical schools and the expense involved in educating a doctor—just to mention a few.

Suffering acutely from this disproportionate growth in the population and its doctors are small communities and rural areas. In Kentucky there are several counties which have less than half a dozen M.D.'s for the entire populace of that county. Many communities in our state have no ready medical facilities and must depend upon those of the larger towns and cities. This problem is not unique in Kentucky; the rural areas of other states face a similar situation.

The Kentucky State Medical Association has done much to relieve this dearth of medicine in rural areas by its Rural Scholarship program. Medical students receive tuition funds for their entire four years in medical school in return for which they agree to practice in a rural area of Kentucky which most desperately needs physicians. This is a great step forward in providing adequate medical care throughout the entire state, but it is still not enough.

Many communities have attempted to lure physicians by providing rent free modern offices and other such enticements. These have been only partially successful. It appears to me that rural communities could solve their problem of medical shortage by more simple means. The desire to study medicine exists in many young high school students in these rural communities today but because of lack of funds and encouragement they never act on their desire.

Would it not be more practical for a community to stimulate these students' interest, provide scholarship funds for their college and medical school training and, as it were, sponsor their own doctor from their own community? Such a new physician would be bound to the community with more than monetary ties or a feeling of obligation, for this would represent to him the people who made it possible for him to realize his goal in life, and of great significance, too, the community would gain a physician to care for its people.

It would behoove civic organizations or private groups of citizens who are living in physician-deprived areas to look in their high schools today for those young persons interested in a medical career. A few dollars invested in their medical training could very easily point the way toward sufficient medical care for many future generations.

Olson Huff, President
University of Louisville SAMA

Obstetrics and Gynecology Course Is Again Offered

The postgraduate course in obstetrics and gynecology sponsored by the Postgraduate Medical Education Office of the Kentucky State Medical Association and the University of Louisville Medical School Department of Obstetrics and Gynecology will again be offered at Louisville General Hospital in 1962. Supervisor is Douglas M. Haynes, M.D., professor and chairman of the Department.

The one-week course, limited to two physicians per week, will be offered during the entire year with the exception of the following weeks: Week of April 2, April 30, May 21, September 17, October 15, October 22, October 29, November 12 and December 17.

During June teaching sessions will be reduced. Doctor Haynes will be away during August, but there will be the most opportunity for practical experience during that month. The individual preference of the trainee will be consulted.

The program is acceptable for 42 hours of Category I credit by the Kentucky Academy of General Practice.

Kentucky Activities

FEBRUARY

22	**Lymphomas, University of Kentucky Medical Center, Lexington, Ky.**
22	*KSMA Interim Meeting, Gabe's Restaurant, Owensboro, Ky.*
27	Postgraduate Course, Arthritis and Rheumatic Diseases. Norton Infirmary, Louisville, Ky.

MARCH

5-8	Southeastern Surgical Congress, Louisville.
8	**Cancer Teaching Program, The Role of Exfoliative Cytology in Medicine, 7:30 PM, University of Kentucky Medical Center, Lexington, Ky.**
12	**CARDIOVASCULAR SURGERY, Postgraduate Course, University of Kentucky Medical Center, Lexington, Ky.**
16-17	Kentucky Chapter, American College of Surgeons Sectional, Lexington, Ky.
20-22	Kentucky Hospital Association, Louisville, Ky.
22	Kentucky Industrial Medical Association, Louisville, Ky.
28	Jefferson County Chapter, American Heart Association, Louisville, Ky.

APRIL

10-12	Kentucky Public Health Association, Louisville, Ky.
10-May 29	**PEDIATRICS, Postgraduate Course, Tuesday mornings, Children's Hospital, Louisville, Ky.**
18-20	Kentucky Tuberculosis Association Annual Meeting, Louisville, Ky.
19	Kentucky Pediatric Society, Frankfort, Ky.
25	Kentucky Psychiatric Association, Semi-Annual Meeting, Lexington, Ky.

MAY

9-11	K.A.G.P. Annual Meeting, Louisville, Ky.
17-18	Kentucky Obstetrical & Gynecological Society, Gabe's Restaurant, Owensboro.

Surrounding States

FEBRUARY

14-17	Mid-South Postgraduate Medical Assembly, Memphis, Tennessee.

MARCH

1	Postgraduate course, Management of the Psychiatric Patient in Daily Practice, Vanderbilt University, Nashville, Tennessee.
2-3	Postgraduate course, Selected Topics in Internal Medicine, University of Virginia, Charlottesville, Virginia.
5-6	Postgraduate course, Ophthalmology, Ohio State University, Columbus, Ohio.
5-7	American College of Surgeons Sectional, Sheraton Cadillac, Detroit, Michigan.
7-8	Indiana Academy of General Practice, French Lick, Indiana.
22	Postgraduate Course, Common Pediatric Surgical Problems, Vanderbilt University, Nashville, Tennessee.
22-24	Central Surgical Association. Cincinnati, Ohio.
26-28	American College of Surgeons Sectional, Memphis, Tennessee.

APRIL

2-5	American College of Obstetricians & Gynecologists, Chicago, Illinois.
5-7	Postgraduate course, Electrocardiography, University of Virginia, Charlottesville, Virginia.
6-8	American Society of Internal Medicine, Philadelphia, Pennsylvania.
6-13	A.A.G.P. Annual Meeting, Las Vegas, Nevada.
8-11	Tennessee State Medical Association, Annual Meeting, Knoxville, Tennessee.
9-13	American College of Physicians, Philadelphia, Pennsylvania.
16-18	American Association for Thoracic Surgery, St. Louis, Missouri.
23-28	American Academy of Neurology, New York, New York.
30-May 2	American Academy of Pediatrics Spring Session, New York, New York.

MAY

13-17	Ohio State Medical Association Annual Meeting, Columbus, Ohio.
13-17	Illinois State Medical Association Annual Meeting, Chicago, Illinois.
28-30	American Ophthalmological Society, Hot Springs, Virginia.
31-June 2	American Gynecological Society, Hot Springs, Virginia.

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Research in the Service of Medicine

Doctor Edward Gall To Discuss Lymphomas at U. of K.

Edward A. Gall, M.D., professor of pathology and chairman of the Department of Pathology at the University of Cincinnati, will speak on "Lymphomas," February 22, at the University of Kentucky Medical Center. The address will be presented at 7:30 p.m. in Medical Center Room MN 263. Doctor Gall is also director of pathology at the Cincinnati General Hospital.



Doctor Gall

On March 8 there will be a cancer teaching program featuring William M. Christopherson, M.D., chairman of the Department of Pathology at the University of Louisville School of Medicine.

The lectures are coordinated by the Subcommittee on Cancer Teaching of the University of Kentucky College of Medicine and are supported through a grant from the U. S. Public Health Service.

Course On Trauma To Be Held

The Sixth Postgraduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 25-28 in the John B. Murphy Memorial Auditorium, Chicago.

A faculty of teachers from Chicago's five medical schools and several distinguished speakers from outside Chicago will discuss many phases of trauma. Particular emphasis will be on hand injuries, plastic surgery, tendon injuries, peripheral nerve injuries, fractures and dislocations in adults and children; trauma to the face, chest, abdomen, blood vessels and genito-urinary tract; bone grafts, athletic injuries, tetanus, shock and trauma to the lumbar discs.

$500 Scholarships Available for U. of L. Med. Freshmen

Thirty scholarships of $500 each will be available to freshmen entering the University of Louisville Medical School next fall, according to J. Murray Kinsman, M.D., U. of L. Medical School dean.

The new program, aimed at attracting more well qualified students, would consist of scholarships from money donated by the alumni and they would not have to be repaid. They are intended for one year's study, but could be renewed in subsequent years. Students receiving the loans must be recommended by alumni and must, of course, meet the entrance requirements.

In announcing the scholarships, Dean Kinsman said only occasional sums have been available for scholarships in the past, such as a $16,000 foundation grant this year that is not expected to be available next year.

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Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

Digest of the Minutes of the KSMA Board of Trustees Meeting—Dec. 14, 1961

The Board of Trustees held its third regular meeting, a day-long session, Thursday, December 14, at the Brown Hotel in Louisville.

Replacements were made of absentees on councils and committees who had been named earlier and who could not serve.

The chairman of the Building Committee, George F. Brockman, M.D., Greenville, reported that the new Headquarters Office Building would be ready for occupancy prior to February 1. The Board authorized the purchase of a new typewriter and approved new stationery which included a miniature picture of the new building.

The Board of Trustees then voted an expression of appreciation to the Building Committee for the excellent work it had done.

On recommendations of the Council on Communications and Public Services, the Board voted to ask each county medical association to cooperate fully in the Medical Self-Help Program of Civil Defense.

Recommendations of the Council on legislative activities were heard. The Board authorized a bill on immunization to be introduced and gave consideration to other matters.

The Legislative Council's recommendations for the organization of the Kentucky Educational Medical Political Action Committee to be known as KEMPAC, were read and approved without dissent. The Board then proceeded to consider and elect a Board of Directors for KEMPAC. It was noted that while the directors on the Board of KEMPAC are selected by KSMA, the operation of KEMPAC is separate and apart from KSMA.

The Steering Committee report on the campaign to hold meetings in each one of the trustee districts during January and the early part of February was made by its chairman, G. L. Simpson, M.D., president. Plans for these meetings were thoroughly explained.

The Board voted to hold the 1966 annual meeting September 20, 21 and 22.

In other actions, the Board voted not to change its policy relative to the refunding of dues; passed a resolution commending W. Vincent Pierce, M.D., to be read at the time he was honored by the Campbell-Kenton County Medical Association, at a special dinner on December 16; voted to express appreciation to J. Alden Bishop, M.D., of Jeffersontown, for the splendid contribution he is making through the radio program FUN FAIR P.M. on WHAS and finally the Board voted to extend invitations to the Deans of both Medical Schools to attend its meetings as guests of the Board whenever possible.

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R. CHARMAN CARROLL, M.D.
Medical Director

ROBERT L. CRAIG, M.D.
Associate Medical Director

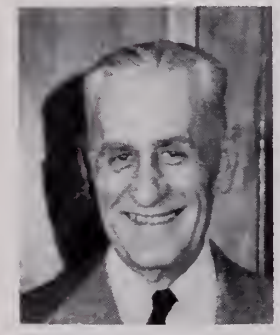
JOHN D. PATTON, M.D.
Clinical Director



Orion Leon Higdon, M.D., Paducah, (third from left) was sworn in as a member of the Kentucky State Board of Health by Governor Bert T. Combs (right) on January 18. Others in the picture are: (left) Russell Teague, M.D., state health commissioner, and Doctor Higdon's daughter. Doctor Higdon succeeds the late William H. Fuller, M.D.

State Board of Health Member Dies at Mayfield

William H. Fuller, M.D., 65, Mayfield, died at his home Friday, January 5. He limited his practice to Eye, Ear, Nose and Throat.



Doctor Fuller

Doctor Fuller, who was a graduate of Eclectic Medical College, Cincinnati, Ohio, in 1922, headed the staff of the 75-bed Fuller-Morgan Hospital in Mayfield where he had practiced more than 40 years.

A member of the State Board of Health for 30 years, Doctor Fuller was widely known in the Purchase as a civic leader.

The House of Representatives of the Kentucky General Assembly adjourned January 17 in memory of Doctor Fuller and extended sympathy to members of his family in a special resolution.

Commissioner Reports On Expanded Services

Increased growth and expansion of public health services, facilities and activities highlighted the past fiscal year, according to the State Department of Health's annual report to the Governor. Russell E. Teague, M.D., Commissioner of Health, pointed out the completion of two new hospitals, five public health centers and over $1,000,000 worth of sewage treatment plants as concrete evidence of the growth of Kentucky's health facilities.

The Department established three new divisions to work in the fields of radiological health, alcoholism and medical care. Many existing programs were expanded to provide greater service and better health for Kentucky's citizens. These were chiefly in the areas of chronic and communicable disease control, engineering, maternal and child health, occupational health and venereal disease control.

Major research projects of the Department included a testing program to locate all cases and carriers of phenylketonuria, a metabolic disease which, if untreated, causes severe mental retardation and a three-year accident prevention control program to study the nature and causes of accidents among school-age children as a basis for effective educational programming.

At the close of the fiscal year, 92 county health departments had the services of 37 medical health officers. The number of counties in the State under the Public Health Foundation Program, which provides additional state funds to counties that are eligible, increased from 66 in the preceding year to 77 counties in 1960-61.

Geriatrics Essay Contest Planned

"Institutional Care of the Aged" is the subject of the first annual essay contest of the National Geriatrics Society aimed at gathering valuable information and promoting progress in this area. All members of the Association are invited to compete in the contest. Deadline for entries is March 15.

All papers are to be judged anonymously and identification numbers may be obtained from Joseph B. Enos, M.D., president, P. O. Box 2605, Niles, California. All entries should be sent to the same address. Prizes range from $500 for the first prize; $300 for second; $200 for third, and $100 for fourth, fifth, and sixth.

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Recent medical literature[1-27]—adding to an already massive bibliography—continues to document the effectiveness of well-tolerated Terramycin in respiratory and other infections.

Recent bibliography: 1. A.M.A. Council on Drugs, New and Nonofficial Drugs 1961, Philadelphia, Lippincott, 1961, pp. 142-147. **2.** Beckman, H.: The Year Book of Drug Therapy, Chicago, Yr. Bk. Pub., 1961, p. 271. **3.** Eastman, N. J., and Hellman, L. M.: Williams Obstetrics, ed. 12, New York, Appleton-Century-Crofts, 1961, pp. 845-1035. **4.** Keefer, C. S., in Modell, W.: Drugs of Choice 1960-1961. St. Louis, Mosby, 1960, pp. 141, 146, 147. **5.** Huang, N. N.: J. Pediat. 59:512, 1961. **6.** Smith, R. C. F.: Brit. J. Clin. Practice 15:345, 1961. **7.** Asay, L. D., and Koch, R.: New England J. Med. 262:1062, 1960. **8.** Berry, D. G., et al.: Lancet 1:137, 1960. **9.** Osol, A., et al.: The Dispensatory of the United States of America, ed. 25, Philadelphia, Lippincott, 1960, pp. 953, 1556. **10.** Adams, A. R. D.: Brit. M. J. 1:1639, 1960. **11.** Jung, R. C., and Carrera, G. M.: Dis. Colon & Rectum 3:313, 1960. **12.** De Lamater, J. N.: Am. J. Gastroenterol. 34:130, 1960. **13.** Stewart, W. H., et al., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. II, chap. 5, p. 19. **14.** Wellman, W. E., and Herrell, W. E., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. I, chap. 44, p. 13. **15.** Wenckert, A., and Robertson, B.: Acta chir. scandinav. 120:79, 1960. **16.** Alstead, S.: Dilling's Clinical Pharmacology, ed. 20, London, Cassell, 1960, p. 462. **17.** Grover, F. W.: Texas J. Med. 57:355, 1961. **18.** Gardiner, W. P., and Gomila, R. R., Jr.: Scientific Exhibit, Venereal Disease Seminar, U.S. Public Health Service, Feb. 28-Mar. 3, 1961. **19.** Jacques, A. A., and Fuchs; V. H.: J. Louisiana M. Soc. 113:200, 1961. **20.** Nathan, L. A.: Scientific Exhibit, 15th Clinical Meet., A.M.A., Denver, Col., Nov. 26-30, 1961. **21.** Ullman, A.: Delaware M. J. 32:97, 1960. **22.** Lamphier, T. A.: Scientific Exhibit, New York State M. Soc. Meet., New York, May 7-13, 1960. **23.** Freier, A.: Paper presented at Michigan Soc. Obst. & Gynec., Detroit, May 3, 1961. **24.** Logan, K. M.: Scientific Exhibit, Ann. Meet., Ohio Acad. Gen. Practice, Cincinnati, Sept. 13-14, 1961. **25.** Altemeier, W. A., and Wulsin, J. H. (A.M.A. Council on Drugs Report): J.A.M.A. 173:527, 1960. **26.** Krol, W. J.: J. Abdom. Surg. 3:78, 1961. **27.** Potempa, J.: Med. Klin. 56:352, 1961.

In Brief

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KAGP Seminar Attended by 121

The annual Northern Kentucky Seminar presented by the Kentucky Academy of General Practice was attended by 121 physicians of the area. The program featured a Cardiovascular Symposium with outstanding speakers and was held January 18 at the Sheraton Gibson Hotel, Cincinnati, Ohio. Richard D. Kruer, M.D., Southgate, was program chairman. The program was approved for six and one half hours of Category I credit by the AAGP.

Physicians' Aid Requested In Leukemia Study

The following statement is offered at the request of Edwin Cameron, M.D., director of the Division of Chronic Disease Control at the Kentucky Department of Health:

"The cooperation of physicians is requested in a study of chronic myelogenous leukemia being conducted by the Chemotherapy Service of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Md.

"Referrals of patients with chronic myelogenous leukemia are needed including some treatment refractory patients with high white blood cell counts and platelet counts, for studies of newer chemotherapeutic agents and as a source of white cells and platelets for *in vitro* and *in vivo* study. Accepted patients will be hospitalized for approximately 8 to 12 weeks.

"Physicians who wish to have their patients considered for the study may write or telephone: Paul P. Carbone, M.D., Chemotherapy Service, Medicine Branch, National Cancer Institute, Bethesda 14, Md. Telephone: 496—4251."

General Hospital Raises Pay

Interns and residents at General Hospital, Louisville, will get a $50-a-month pay raise in 1962. The Fiscal Court voted to provide funds in the county's 1962-3 budget to cover half the cost of the raises and Mayor William O. Cowger said the city would provide money to cover the other half.

Murray Kinsman, M.D., dean of the U. of L. Medical School, and Gradie Rowntree, chairman of the City-County Health Board, had asked that the pay of interns and residents be raised from $100 to $200 a month. Doctor Kinsman explained that a double raise was needed to bring the pay in line with that being offered elsewhere, but commenting on the $50 raise he said, "We're grateful for what we get."

Merrill W. Schell, M.D., Owensboro, has been chosen president of the Western State College Alumni Association. A native of Bowling Green, Doctor Schell, received a B.S. degree from the College in 1943. He will be officially installed during the spring commencement exercises and will serve a one-year term.

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Council Committee Reports

Annual Meeting Scientific Program Committee

E. D. Pellegrino, M.D., Lexington, Chairman, Presiding

Louisville **December 28, 1962**

Broad objectives for the 1962 Annual Meeting scientific program, to be held in Louisville September 18, 19 and 20, were considered by the committee.

Following discussion it was decided to seek the cooperation of the specialty group presidents in structuring half-day scientific programs around a general theme and presenting the material in this connection in some depth.

Potential subjects were selected and it was agreed that they would be presented by the chairman at the meeting of the specialty group presidents scheduled for Thursday, January 4.

Specialty Group Presidents' Meeting

G. L. Simpson, M.D., Greenville, KSMA President, Presiding

Louisville **January 4, 1962**

The President explained that the general purpose of the meeting of the specialty group presidents was to outline the general objectives and procedures for specialty group participation in the 1962 KSMA Annual Meeting.

The chairman of the Scientific Program Committee, E. D. Pellegrino, M.D., Lexington, was then asked to explain the innovations planned by the Program Committee in seeking cooperation of the various specialty group presidents in building a scientific program for half-day sessions around one general subject.

Following discussion the specialty group presidents agreed to cooperate and undertake to select guest speakers to fit into these plans.

One of the critical problems facing medicine today is the growing tendency of the working man to equate health care with a muncipally owned service while at the same time demanding discount house prices. *—Justin C. Smith, Dean, Law-Medicine Center, Western Reserve University.*

The flow of new and potent drugs today compels the physician to continue his postgraduate education as he never had to before. The more specific the drug—and every effort of pharmaceutical research is bent toward making drugs more pinpointed in action against particular conditions—the greater the likelihood of some unwanted side reaction . . . Much pharmaceutical advertising warns the buyer not to use the product. It's rather like an ad for a washing machine which says, "This is a good washing machine but don't put a shirt into it or you may ruin it. It does a good job on sheets but is lousy on socks."—William B. Graham, President, Baxter Laboratories.

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In Memoriam

WILLIAM CARL GRANT, M.D.
Winchester
1881-1961

William Carl Grant, M.D., a retired Winchester physician, died of a heart attack at his home on December 27. Doctor Grant received his medical degree from the Hospital College of Medicine in Louisville in 1904. After six years of practice in Louisville, he moved to Winchester where he practiced from 1910 until his retirement a few years ago.

HARVEY R. HENRY, M.D.
Winchester
1885-1961

H. R. Henry, M.D., retired physician and surgeon and a charter member of the Winchester Hospital Board, died December 9 of a heart ailment.

A native of Montgomery County, he graduated from the Kentucky School of Medicine, Louisville, in 1908. Doctor Henry who was 76 had been hospitalized for several days before his death. He was chairman of the board of the Peoples Commercial Bank and a former president of the Old Commercial Bank.

C. V. HIESTAND, M.D.
Campbellsville
1872-1962

C. V. Hiestand, M.D., Campbellsville, died January 14 at Rosary Hospital. Doctor Hiestand was graduated in 1896 from the old Louisville Medical College and began his practice at Merrimac in Taylor County. He moved his offices to Campbellsville in 1918. At the time of his death he was serving as chairman of the Taylor County Board of Health.

In 1953 Doctor Hiestand was named "doctor of the year" by the Kentucky Academy of General Practice. He received the Governor's Medal in 1958 for exceptional meritorius contribution to the health and welfare of Kentuckians. Last spring, he estimated that during his 65 years of practice he had delivered 6,000 babies and worn out 32 automobiles.

Doctor Hiestand also served nine years as mayor of Campbellsville.

LEO C. G. SAUTER, M.D.
Newport
1895-1962

Leo C. G. Sauter, M.D., Newport, died at St. Luke Hospital, Ft. Thomas, January 16. Doctor Sauter was coroner of Campbell County and had served in that position since 1943 when he was appointed to succeed his brother, Martin L. Sauter, M.D., who also died in office. Doctor Sauter received his medical degree from the Eclectic Medical College, Cincinnati, in 1920.

The Section on Ophthalmology and Otolaryngology of the Southern Medical Association, announces that it will now accept papers to be considered for presentation before the next annual meeting at Miami Beach, Florida, November 12-15, 1962. Papers will be accepted for consideration for presentation until May 15, 1962. For further information, contact the Secretary, Albert C. Esposito, M.D., Suite 1212, First Huntington National Bank Building, Huntington 1, West Virginia.

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County Society Reports

Bell County

The Bell County Medical Society has elected Buell B. Mills, M.D., Pineville, as its new president. Other officers elected to serve with Doctor Mills were: Frances Forde, M.D., vice-president and Frank T. Smith, M.D., secretary-treasurer. Doctor Forde and Doctor Smith are from Middlesboro.

Hardin County

David T. Lewis, M.D., Elizabethtown, was elected president of the Hardin County Medical Society at its regular monthly meeting on December 14. Other officers elected for 1962 were: O. M. Richardson, M.D., vice president, and Ollie B. Emerine, M.D., secretary-treasurer. Both are from Elizabethtown.

Jefferson County

Louis M. Foltz, M.D., was named president-elect of the Jefferson County Medical Society, January 15. Everett H. Baker, M.D., moved up from the post of president-elect to president.

Other new officers elected are: Edwin P. Solomon, M.D., first vice president; L. Douglas Atherton, M.D., second vice-president; McHenry S. Brewer, M.D., secretary, and Norman Glazer, M.D., treasurer.

Elected delegates to the Kentucky State Medical Association at the January meeting were: Charles G. Bryant, M.D.; James W. Davis, M.D.; Arthur L. Goodman, M.D.; John A. Hemmer, M.D.; Richard E. Mardis, M.D.; Herman R. Moore, Jr., M.D.; James M. Riley, Jr., M.D.; John J. Robbins, M.D.; Bernard J. Schoo, M.D., and Samuel D. Weakley, Jr., M.D. All are from Louisville.

McCracken County

The monthly meeting of the McCracken County Medical Society was held November 15, with H. D. Abell, Jr., M.D., president, presiding. Walter Johnson, M.D., introduced the speakers for the evening: Mr. Tom Garrett, Senator, District Two; Mr. Fred Morgan, Representative, District Five; and Mr. Julian M. Carroll, Representative, District Four.

All three men made brief introductory remarks concerning the upcoming session of the State Legislature, covering the problems of re-districting, financial problems, etc. Mr. Morgan wants to amend the state sales tax, removing food and drugs from the tax.

Doctor Widener asked what could be done to extend the period of hospitalization under the Kerr-Mills Bill as six days is not enough time for many surgical procedures that otherwise many of these patients might receive under the bill. Mr. Garrett stated that he thought because the Kerr-Mills Bill was new, the manner in which it had been implemented was unrealistic with the department now having the authority to change regulations and abide by them.

Mr. Carroll mentioned the problem of State aid to illegitimate children in Kentucky stating that he was not against these children, but was against the manner in which much of the money was going down the drain as used by the mothers of these children.

Doctor Johnson told the three men present of KSMA interest in the Required Immunization Bill to be presented at this session and each man stated that he would vote for this bill. Mr. Morgan stated that if the Governor would support the bill, it would be easily passed as an administration bill.

Mr. Morgan and Mr. Garrett agreed that the Constitution of the State of Kentucky is outmoded and should be changed. Mr. Morgan stated that there were only 25-30 actual working days in a session of the Legislature.

Mr. Garrett told of a bill to be sponsored by the Kentucky Bar Association permitting doctors and lawyers to incorporate, thus seeking tax relief for retirement.

The meeting was adjourned at 9:10 p.m.

Muhlenberg County

Joseph D. Stokes, M.D., was elected president of the Muhlenberg County Medical Society December 13. R. F. Mobbs, M.D., was elected vice president and G. F. Brockman, M.D., secretary.

G. L. Simpson, M.D., KSMA president, reported on the establishment of AMPAC and KEMPAC. A summary of the profession's legislative program was presented and plans made for implementing it on a local level.

On motion of Doctor Brockman, seconded by Doctor Simpson, the Society recognized "the distinguished services of W. Vinson Pierce, M.D., of Covington, Ky., to organized medicine," and invited "these services to the attention of the Committee on Awards of the Kentucky State Medical Association for their consideration in recommendations for the Association's Distinguished Service Medal."

The University of Louisville School of Medicine now has an electron microscope which magnifies objects up to 160,000 times their original size. The $30,000 microscope was purchased with a grant of $90,000 from the National Institute of Health to W. M. Christopherson, M.D., and G. R. Schrodt, M.D., of the Department of Pathology. They will use the remainder of the grant to conduct cancer experiments with the aid of the microscope.

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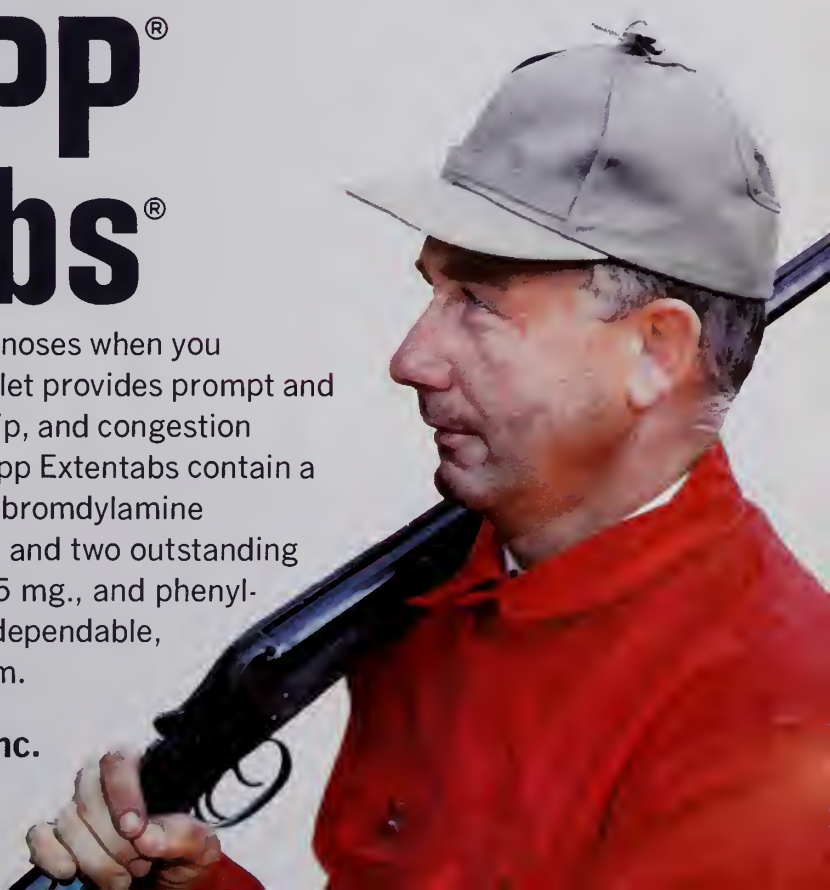


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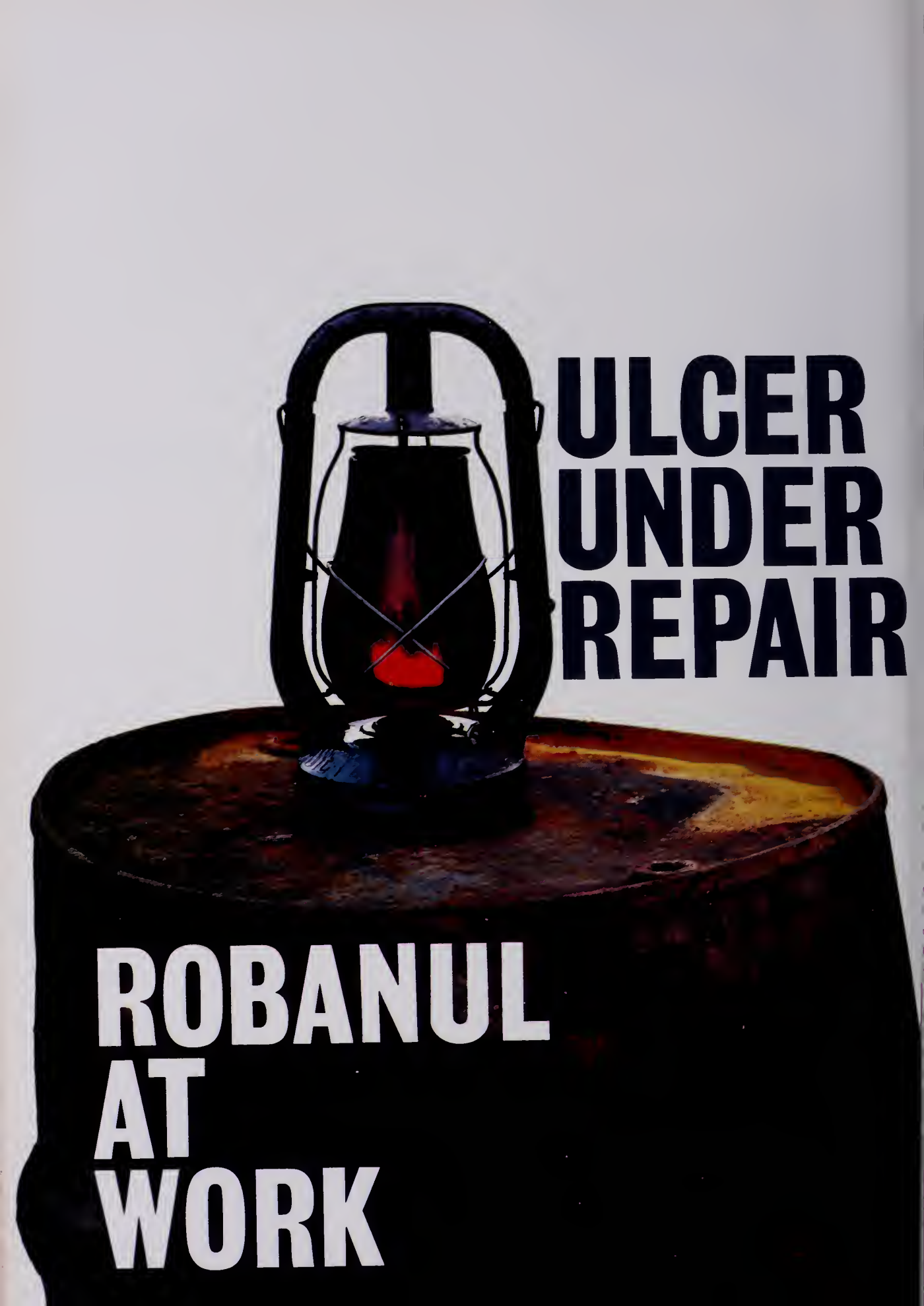
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From Robins research comes Robanul (generically, Glycopyrrolate), first of the "rigid-ring" anticholinergics, representing what may well be the most important advance in anticholinergic chemistry in a decade.

Clinically, both Robanul and Robanul-PH (with phenobarbital) have demonstrated a remarkable ability to provide within 90 minutes—and maintain for 6 to 10 hours—those nearly ideal pharmacologic healing conditions that mean prompt relief of ulcer pain and a successful recovery of your ulcer patient.

There are always important questions about any new therapeutic agent. Below are answers to some of the common ones asked about Robanul:

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Glycopyrrolate (Robins), 1.0 mg. per tablet (U.S. Pat. No. 2,956,062)

ROBANUL™-PH

Robanul with phenobarbital, 16.2 mg. per tablet

First of all, what does "rigid-ring" mean?
Briefly, this: it describes the use of a fixed pyrrolidine pentagon, or rigid ring, which guarantees a constant 2-carbon distance between reactive parts of the molecule. In line with the "receptor site" concept of the mechanism of action of anticholinergics, this almost inflexible molecule is theoretically more likely to "fit" only certain receptor sites.

Theories are all right, but is Robanul really more selective?
Yes! Evidence of its selectivity can be seen by the surprising lack of typical secondary anticholinergic effects (dry mouth, blurred vision, etc.) that occur at the effective dosage level of 1 to 4 mg. a day. Out of 499 duodenal and gastric ulcer patients treated at this level in investigative studies, only 4.4% had complaints of moderate to severe effects.

How is it for reducing gastric acid?
One investigator[1a] found that a 2 mg. dose of Robanul lowered acid secretion 73% in one hour (compared to basal-hour period) and 84% in two. A 4 mg. dose stopped secretion over 94% in one hour and 97% in two!

What about acidity, or concentration of acid?
In one study, glycopyrrolate produced significant suppression of pH to 4.5 or higher in 5 of 5 duodenal ulcer patients given a 4 mg. dose, 7 of 8 patients given 2 mg., and 4 of 5 patients given 1 mg.[1b]

Will Robanul depress gastric hypermotility?
In another study[2] with six subjects Robanul decreased gastric motility in every patient. Within 40 minutes after administration of 2 mg. of Robanul, the frequency of gastric antral contractions decreased from 1 every 24 seconds to only 1 every 2½ minutes. Young and Sun[1c] found a similar effect. Moreover, their results in 7 patients indicated that Robanul, in a dose of 2 mg., did not produce delay in gastric emptying or intestinal transit.

What's the best dosage schedule for Robanul?
It should be adjusted for each patient, and this is where Robanul offers another big advantage. Its "titratability" is unmatched among anticholinergic agents. Robanul's potency makes possible a recommended starting dose of only one milligram t.i.d. Yet its selectivity usually permits much leeway for dosage adjustment upward as necessary, to achieve the most effective dose level for each patient while maintaining a low incidence of undesirable effects on other organ systems.

Is there anything else Robanul does for peptic ulcer?
Much more! For instance, 2 mg. cuts pepsin production about 50% in two hours; 4 mg., about 65%.[1a]...There is evidence that Robanul combats hormonal aspects of gastric secretions as well as vagal in many patients... ...Its activity lasts long enough to reduce acid secretion all night long.[3]...Many ulcer patients have remarked about its fast relief of pain....

One last question: Why not prescribe Robanul for your next duodenal ulcer patient and see for yourself just exactly how effective it is?

References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. 2. W. C. Breidenbach: Investigative clinical report, March, 1961. 3. I. A. Feder: Investigative clinical report, May, 1961.

Additional information upon request.

A. H. Robins Company, Inc., Richmond 20, Va.

30th Annual Southeastern Surgical Congress

Brown Hotel, Louisville, March 5-8

Surgeons' Section

MONDAY, MARCH 5

Waltman Walters, M.D., (Guest), Rochester, Minn., "Complicated Lesions of the Biliary Tract and Their Treatment"
Samuel F. Marshall, M.D., (Guest), Boston, Mass., "Choice of Operation for Peptic Ulcer"
Roger E. Wilcox, M.D., Beckley, W. Va., "Subtotal Gastrectomy vs. Antral Resection and Vagectomy"
Guy P. Sharpe, Jr., M.D., Greenwood, Miss., "Trends in Gastric Surgery"
Carl E. Badgley, M.D., (Guest), Ann Arbor, Mich., "Recognition and Treatment of the Irreducible Early Post-natal Congenital Dislocation of the Hip"
Rudolph A. Light, M.D., Oxford University, England, "The Place of the British House Surgeon in the National Health Scheme"
Walter C. Jones, M.D., Miami, Fla. Presidential Address
George M. Knauf, M.D., Col USAF, Patrick Air Force Base, Fla., "Medical Aspects of the Mercury Space Program"
Carl E. Badgley, M.D., (Guest), Ann Arbor, Mich., "The Frequent Failure of Recognition of the Lesion and the Need of Early Therapy, Fracture Dislocation of the Hip"
D. Franklin Milam, M.D., Morgantown, W. Va., "Urinary Tract Complications of Pelvic Fractures"
Carl Berg, M.D., Washington, D.C., "Fracture of the Humerus and the Hanging Cast"
Donald J. Davis, M.D., Orlando, Fla., "Traumatic Chest Injuries, Experience in a Community Hospital"
S. Benjamin Fowler, M.D., Nashville, Tenn., "Treatment of the Hand in Rheumatoid Arthritis"
Panel Discussion: "Pitfalls in Management of Patients With Multiple Injuries"
Roger T. Sherman, M.D., Memphis, Tenn., Moderator
Garber Galbraith, M.D., Birmingham, Ala.
Curtis Artz, M.D., Jackson, Miss.
Rudolf J. Noer, M.D., Louisville, Ky.
Carl Berg, M.D., Washington, D. C.
Carl E. Badgley, M.D., Ann Arbor, Mich.

TUESDAY, MARCH 6

Howard C. Taylor, Jr., M.D., (Guest), New York, N. Y., "Special Indications and Comparative Results in Hysterectomy Performed by Various Techniques"
Rowland Zeigler, M.D., Florence, S. C., "Cesarean Hysterectomy"
Discusser: Douglas M. Haynes, M.D., Louisville, Ky.
Abe Mickal, M.D., New Orleans, La., "Carcinoma of the Breast in Pregnancy"
Samuel Karlin, M.D., New Orlean, La., "Intrathoracic Goiters"
Robert G. Chambers, M.D., Baltimore, Md., "Surgical Treatment of Lesions of the Parotid Gland"
Orvar Swenson, M.D., (Guest), Chicago, Ill., "Management of Infants with Jaundice"
Samuel W. Windham, M.D., Dothan, Ala., "Some Facet of Gallbladder Surgery"
John N. Classen, M.D., Baltimore, Md., "Pancreatitis"
Forum on Progress in Surgery, ten papers of ten minutes each, to be announced

WEDNESDAY, MARCH 7

Samuel F. Marshall, M.D., (Guest), Boston, Mass., "Earlier Resection in One Stage for Diverticulitis of Colon"
Felda Hightower, M.D., Winston-Salem, N. C., "Methods of Approach to Low Lying Tumors in the Rectum"
Edgar Boling, M.D., Atlanta, Ga., "Villous Tumor of the Colon and Rectum"
J. Robert Massie, Jr., M.D., Richmond, Va., "Benign Solitary Ulcers of the Colon"
Howard C. Taylor, Jr., M.D., (Guest), New York, N. Y., "The Diagnosis and Treatment of Pelvic Pain of Obscure Origin in Women"
Major F. Fowler, M.D., Atlanta, Ga., "Double Penis: Report of Case With Surgical Management"
Discusser: J. Andrew Bowen, M.D., Louisville, Ky.
J. Garber Galbraith, M.D., Birmingham, Ala., "Newer Concepts in Management of Intracranial Vascular Anomalies"
Wendell B. Thrower, M.D., Charleston, S. C., "Safe Conduct of the Patient Through Cardio-vascular Surgery"
J. Herman Mahaffey, M.D., and Daniel E. Mahaffey, M.D., Louisville, Ky., "Successful Surgical Repair of Abdominal Aortic-Vena Cava Fistula Caused by Rupture of an Arteriosclerotic Aneurysm"
Waltman Walters, M.D., (Guest), Rochester, Minn., "Cancer of the Stomach in the United States and in Certain Oriental Countries"
Rudolf J. Noer, M.D., Louisville, Ky., "Mammary Cancer: The Place of Adjunctive Therapy"
James L. Campbell, M.D., Orlando, Fla., "Ten Years' Experience with Radioactive Gold in Prostatic Cancer"
William S. McCune, M.D., Washington, D. C., "The Surgical Management of Malignant Melanoma"
Symposium: "What are the Advances in Cancer Research Which Have Contributed to the Control of Cancer?"
Murray M. Copeland, M.D., Houston, Texas, Moderator
Stuart M. Sessoms, M.D., Bethesda, Md.—from the internist's point of view
Murray M. Copeland, M.D., Houston, Texas—from the surgeon's point of view
Gilbert H. Fletcher, M.D., Houston, Texas—from the radiotherapists' point of view

THURSDAY, MARCH 8

Orvar Swenson, M.D., (Guest), Chicago, Ill., "The Problems of Intestinal Obstruction in the Newborn"
George Crile, Jr., M.D., (Guest), Cleveland, Ohio, "Rationale and Results of Simplified Treatment of Cancer of the Breast"
Murray M. Copeland, M.D., Houston, Texas, "The Challenge of the Biologic Aspects of Cancer of the Breast"
Owen Gwathmey, M.D., Richmond, Va., "Prevention of Reflux Following Esophageal Resection, "A New Method," Preliminary Report"
James D. Hardy, M.D., Jackson, Miss., "Pulmonary Hemorrhage: Causes and Management"
Jack Wickstrom, M.D., New Orleans, La., "Skeletal Manifestations of the Hematological Diseases"
John A. Brabson, M.D., Charlotte, N. C., Blood Transfusions. Their Reactions, and Particularly the Do's and Don'ts of Giving a Single Transfusion"
George Crile, Jr., M.D., (Guest), Cleveland, Ohio, "Some Biologic Aspects of Cancer With Special Reference to Cancer of the Thyroid"

Nurses' Section

MONDAY, MARCH 5

Willard H. Parsons, M.D., Vicksburg, Miss., "General Preoperative and Postoperative Nursing Care from the Doctor's Viewpoint"
Panel—"Psychological Aspects of Surgery and Surgical Nursing"
Louis Foltz, M.D., Louisville, Ky., psychiatrist
Robert W. Lykins, M.D., Louisville, anesthesiologist
Mrs. Louise Ezell, R.N., staff nurse
Miss Sue Kapfhammer, R.N., operating room nurse
Miss Margaret Keesee, R.N., recovery room nurse
Panel:: "Burns and Electrolyte Balance"
Curtis Artz, M.D., Jackson, Miss., Moderator
M. J. Jurkiewicz, M.D., Gainesville, Fla.
J. D. Martin, Jr., M.D., Atlanta, Ga.
Mr. Melvin Carson, physical therapist, Louisville, Ky.
Miss LaNelle Blackston, R.N., Jackson, Miss.

TUESDAY, MARCH 6

Panel—"Rehabilitation of the Surgical Patient"
Howard Mahorner, M.D., New Orleans, La., Moderator
Francis Massie, M.D., Lexington, Ky.
Carl Berg, M.D., Washington, D. C.
Mrs. Helen Powers, Staff R.N.
Miss Catherine Racque, visiting R.N.
Miss Mary McDonald, Physical Therapist
Panel—"Unusual Occurrences in Operating Rooms"
Mrs. Frances Ginsberg, R.N., Boston, Mass., Guest Speaker
Donald S. Daniel, M.D., Richmond, Va.
Discussers: Harry Lee Claud, M.D., Washington, D. C.
J. Duffy Hancock, M.D., Louisville, Ky.
E. H. Baker, M.D., Louisville, Ky.
Miss Helen I. Harder, R.N.
Sr. Agnes Regina, R.N.
Mrs. Justine Bradley, R.N.
Miss Colleen Call, R.N.

WEDNESDAY, MARCH 7

Panel—"Nursing in Emergencies"
Benjamin Byrd, M.D., Nashville, Tenn., Moderator, "Management of Emergency Rooms"
Amos Koontz, M.D., Baltimore, Md., "Management of Mass Casualties"
Miss Yosita Murakami, R.N.
Miss Curtsinger, R.N.
Forum on Developments in Nursing Care
Hartwell Wilson, M.D., Memphis, Tenn., Moderator
Richard L. DeSaussure, Jr., M.D., Memphis Tenn., Intensive Care Unit
Miss Tolbert, R.N., Baptist Hospital, Memphis, Tenn.
Walter C. Jones, M.D., Miami Fla., Recovery Room
Miss Sue Kern, Lexington, Ky.

THURSDAY, MARCH 8

Panel—"Open Heart Surgery"
J. Alex Haller, Jr., M.D., Louisville, Ky., Moderator
James D. Hardy, M.D., Jackson, Miss.
Daniel Mahaffey, M.D., Louisville, Ky.
Wendell Thrower, M.D., Charleston, S. C.
Frank Johnston, M.D., Winston-Salem, N. C.
Miss Barbara Hopper, R.N., operating room nurse
Miss Dorothy Ferguson, R.N., recovery room nurse.
Miss Molly Caldwell, R.N., Staff Nurse

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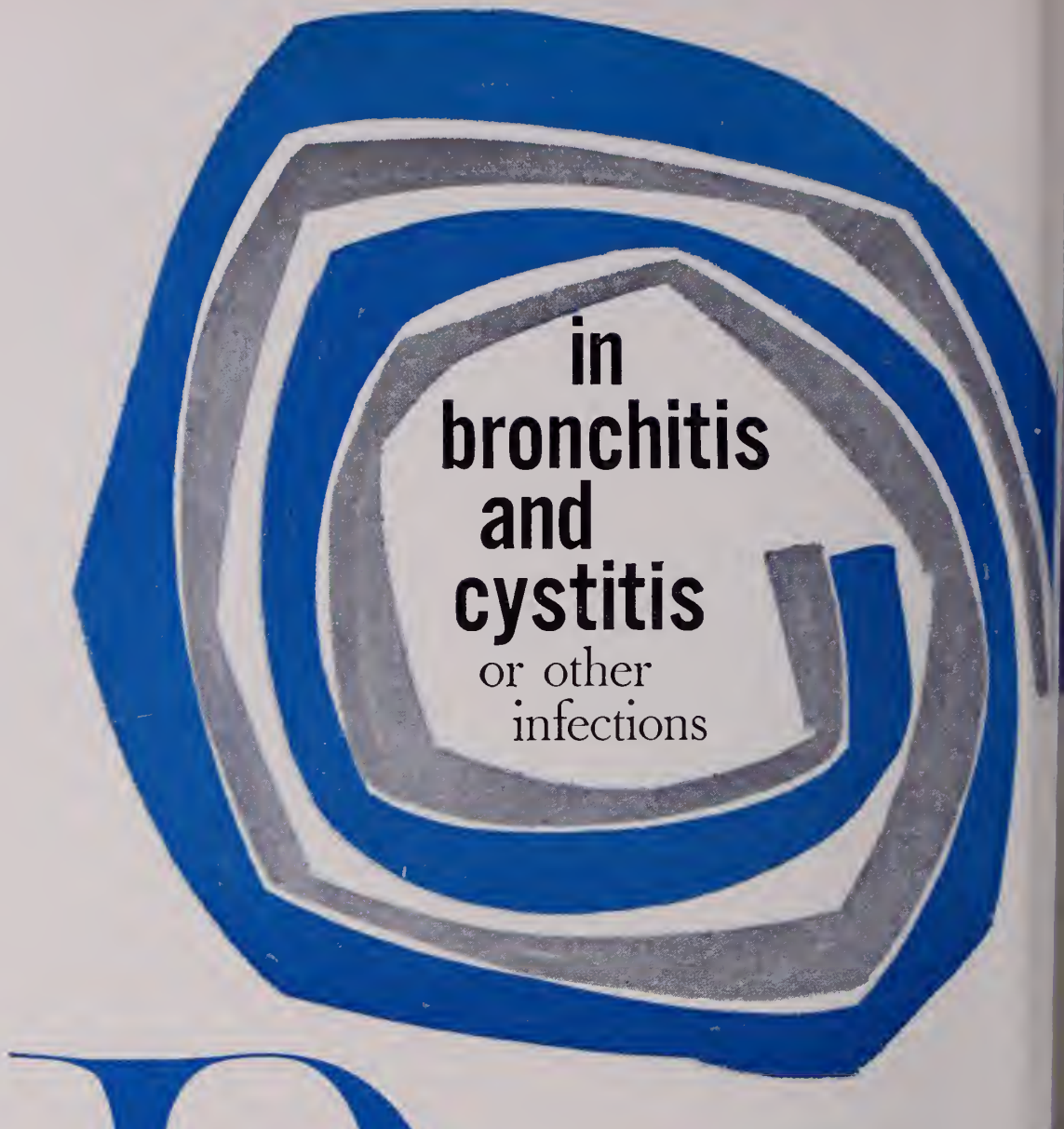
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1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

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IN THE BOOKS



COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT: edited by Curtis P. Artz, M.D., F. A. C. S., and James D. Hardy, M.D., F. A. C. S.; published by W. B. Saunders Company, Philadelphia and London; 1075 pages; price, $23.

About forty per cent of this large volume (1033 pages) deals with general physiologic and metabolic complications encountered by surgeons of all fields. This includes pulmonary, renal, cardiac, and vascular complications as well as wound complications and problems encountered with administration of blood and parenteral fluids. The special problems presented by diabetes, liver decompensation, and nutritional deficiencies are discussed. One chapter deals with the management of pain, and another with the psychological problems in the postoperative period.

The other sixty per cent of the book is devoted to the complications of specific operative procedures. There are chapters devoted to the various areas of general, gynecologic, thoracic, vascular, and urologic surgery. Complications of fractures and peripheral nerve surgery are presented. An attempt is made to include the specific complications in each of the fields of general surgery and in all allied fields. The more highly specialized fields such as eye surgery and brain surgery are discussed.

There are 71 contributors to this volume. They are a very impressive group of highly recognized authorities in the various fields under discussion.

The book is well planned and well written. The surgical philosophies of the various authors are reflected in their writings. It is only natural that any critical reader of this book will take issue with some of the authors on certain points. For the most part, however, this is an excellent review of the subject. It will serve well as a reference book for the surgeon's library.

McHenry S. Brewer, M.D.

MECHANISMS OF DISEASE; An Introduction to Pathology; by Ruy Perez-Tamayo, M.D.; published by W. B. Saunders Company, Philadelphia; 512 pages; price, $14.

This text of 512 pages weighs only three pounds, but packs an intellectual punch many times its weight. The author intends his book "to serve as a guide during the first stage of the study of pathology" and to present "a general survey of the mechanisms of disease." In this reviewer's opinion he attains the latter objective far better than the former. The theme that "disease is not, has never been a thing (but) is a process, neither adding nor subtracting anything from the individual," is explicit in every chapter. Explicit, also, is the author's thesis that disease is a disturbance of homeostasis.

The text is divided into two sections of five chapters each. Part I discusses Degenerative and Regressive Disturbances of Cells and Tissues; Inflammation; Repair, Regeneration and Tissue Transplantation; Disturbances of Growth and Differentiation; General Pathology of Tumors. Part II deals with the General Pathology of Connective Tissues; Host-Parasite Relation; Immune Response; Body Fluids and Electrolytes; and Metabolism and Nutrition respectively. It concludes with a brief dissertation regarding the "Nature of Disease."

The author quotes extensively from the literature. The chapter on metabolism and nutrition concludes with a bibliography of 434 references. Those on the pathology of tumors and of host-parasite relation, with 394 and 243, respectively. The book is enriched by brief historical sketches embellished by photographs of notable contributors to the medical sciences. This is not a book for undergraduate medical or dental students. But it should be a cherished addition to the private library of every physician who aspires to instruct undergraduate medical and dental students, nurses or medical technologists. Frequent reference to its pages will enrich lectures on human disease and suggest provocative questions for further consideration.

Some of the illustrations are taken at too low a magnification to serve any useful purpose. Some lack definitive detail. The print is highly legible, the book pleasingly devoid of misprints, the index adequate.

Harold Gordon, M.D.

PREVENTIVE MEDICINE IN WORLD WAR II—VOL. V.—COMMUNICABLE DISEASES: Edited by Col. John Boyd Coates, Jr., M.C.; Ebbe Curtis Hoff, Ph. D., M.D., and Phebe M. Hoff, M.A.; published by the U. S. Government Printing Office; 530 pages; price, $5.75.

This volume is one in a series comprising the official history of the medical department in the United States Army in World War II. It is the second of three volumes on communicable disease. This one is concerned with communicable diseases transmitted through contact or by unknown means.

Each of the seventeen chapters of this volume discusses a different disease or group of related diseases and is the contribution of one or more of the twenty-seven well qualified authors. The approach to each disease discussed deals with its history, epidemiology, military significance and the preventive and control measures taken and their results.

The writing is generally in agreeable narrative style. Occasional detailed accounts of administrative command action become burdensome, but can be excused when remembering it is written as a history of activity.

Approximately two-fifths of the book deals with venereal disease control. An interesting story of the frustration in dealing with people of different cultures and background unfolds in this section. The next two diseases in quantity of material offered are viral hepatitis, both infectious and serum and poliomyelitis. Also of interest are two disease entities described first during this war period. One, is Bullis Fever, the other recognized in 1942 and referred to as Fort Bragg Fever, remained a mystery as to its etiology until 1952.

Remembering that this book was written primarily as a recorded history of activities of the United States Army Medical Department in World War II, signifies its greatest value, for from such recorded history we learn of the approach to problems by others, their successes and failures. Through analysis of such material we may avoid their failures and improve on their successes. In addition, the book should be interesting reading for those physicians interested in preventive medicine, particularly in its relation to military and community programming. Included in the book are statistics of morbidity mortality rates in a controlled population which may make valuable reference for persons interested in the particular diseases discussed. T. S. Wallace, Jr., M.D.

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1. *Methyl-Testerone-Thyroid in the Treatment of Impotence*, A. S. Titeff *(Prepub. Report)*.
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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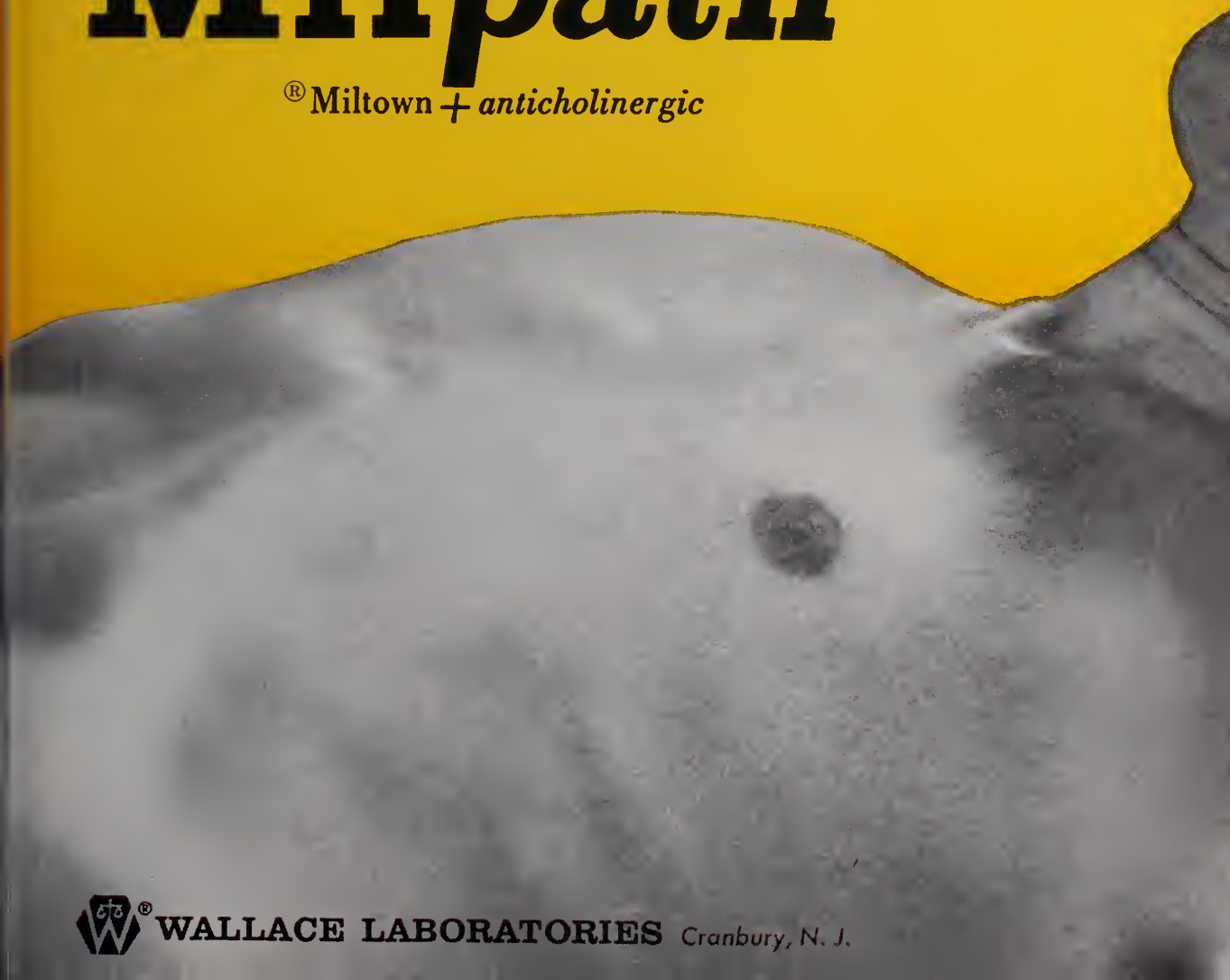
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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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CASE #105—This patient was a 40-year-old married, white, gravida 9, para 8 whose last menstrual period was not stated. She was hospitalized at 2:00 a.m. on November 14, 1960, having passed a fetus of approximately 12 weeks' gestation at midnight. The blood pressure was 100/60. The hemoglobin was 11.8 grams, with a white blood count of 18,000. The temperature was 100°F.

She was given an ampule of ergotrate intravenously and 100 mg. of Demerol intramuscularly for pain. No pelvic findings were recorded. Her pads were checked at 2:20 a.m. and changed; she was having "a large amount of bleeding with a few blood clots." The next nurses' notes were made at 4:25 a.m., when the pads were again changed and she was still bleeding moderately. In addition, she had passed a "small amount of tissue resembling the cord." She received another 100 mg. of Demerol intramuscularly at 5:30 a.m.

At 8:30 a.m. she was examined because of profuse uterine bleeding. The temperature was 99°F. Dilatation and curettage of the uterus were performed under sodium pentothal anesthesia, and a large amount of foul smelling tissue was removed from the uterine cavity which was then packed with a strip of iodoform gauze, as was the vagina.

The curettage specimen showed only necrotic secundines. The immediate postoperative condition was described as poor. She received 1000 cc of five per cent glucose in water; her blood was typed and crossmatched; and she was placed on Combiotic, 2 cc every eight hours.

At 10:30 a.m., blood was noted to be seeping through the packing. The blood pressure was now 82/60, the pulse 120 and weak, and the patient appeared pale. The uterus was manually massaged. At 11:30 a.m., the blood pressure had fallen to 78/50, and the pulse was very weak. The patient was returned to the operating room but no further operative procedure was described. By 6:30 p.m., and despite two transfusions, the blood pressure remained at shock levels, and continued so until the patient's death at 6:25 a.m. on November 15, 1960.

Comments

The committee considered this to be a direct obstetrical death with preventable factors. The definitive treatment of bleeding resulting from an infected incomplete abortion, uterine curettage, was done in this case, but the six-hour delay from admission to operation was considered unjustifiably prolonged. A Pitocin infusion might have helped to reduce bleeding. It appears significant that when the patient was returned to the operating room because of continued vaginal bleeding, no procedure was undertaken to control the bleeding. Since simpler methods had proven unavailing, a hysterectomy was probably indicated.

Curettage of a uterus of the size present in the case in point is usually considered to be a safe procedure, especially after the fetus has been expelled. However, the dangers of perforation and failure to control hemorrhage continue to complicate this common operation; and when the curettage itself fails to stop bleeding, it is fallacious to suppose that a uterine pack will succeed.



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PUBLIC HEALTH PAGE

Kentucky Conferences On Oral Cancer*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

DURING the Spring and Summer of 1961, a series of Cancer Conferences were held for the dentists of Kentucky. The Conferences were the result of a joint effort by the Kentucky Dental Association and the Divisions of Chronic Disease Control and Dental Health of the Kentucky State Department of Health.

Nine Conferences Held

Nine regional Conferences were held at the following locations: Cumberland Falls, Ashland, Pikeville, Covington, Lexington, Bowling Green, Louisville, Owensboro, and Ken Lake Hotel.

Each of the nine Conferences was conducted by Doctor Harold E. Boyer, Professor and Chairman of the Department of Oral Surgery at the University of Louisville, College of Dentistry.

A tenth and final Conference was held at the Fall meeting of the Kentucky Dental Association. The final Conference was built around a panel discussion with the following participants: J. E. Parker, M.D., Department of Pathology, Louisville General Hospital; R. M. Scott, M.D., Department of Radiology, Louisville General Hospital; Condit Moore, M.D., Department of Surgery, Louisville General Hospital. Doctor Boyer served as moderator of the panel discussion.

Dentists and Physicians Attend

The regional Conferences were attended by a total of 568 dentists, 24 physicians, and two nurses. The final Conference was attended by 143 dentists, and four dental hygienists.

Doctor Boyer listed the purposes of the Cancer Conferences as fourfold and summarized them as follows:

Conference Purposes Listed

1. To stress the importance of the early recognition of oral cancer and re-emphasize the challenge that faces the dental profession.
2. To formulate a cancer detection examination that can be done routinely during the dental visit.
3. To review with Kodachrome slides, the story of oral cancer, clinical cases of "pre-cancerous lesions," early cancer, and lesions of differential diagnostic interest as found in the oral cavity.
4. To discuss the microscopic examination, "the biopsy," how-when-where.

Doctor Boyer emphasized during the Conferences that in the past, unfortunately, the mouth has often been a "no man's land." The dentist has considered it a place where the teeth were held, and the physician considered it a pathway to the tonsils. Oftentimes, the patient may have visited both dentist and physician, with neither doing a complete cancer detection examination of the oral structures.

High Mortality Rate Noted

While oral cancer accounts for only a small percentage of the total cancer cases, it has a high mortality rate—a rate that can be lowered only through early recognition and referral for treatment. The dentist has the best opportunity of detecting these lesions of oral cancer at an early stage.

Much interest was shown by those attending the Conferences and many pertinent questions were asked.

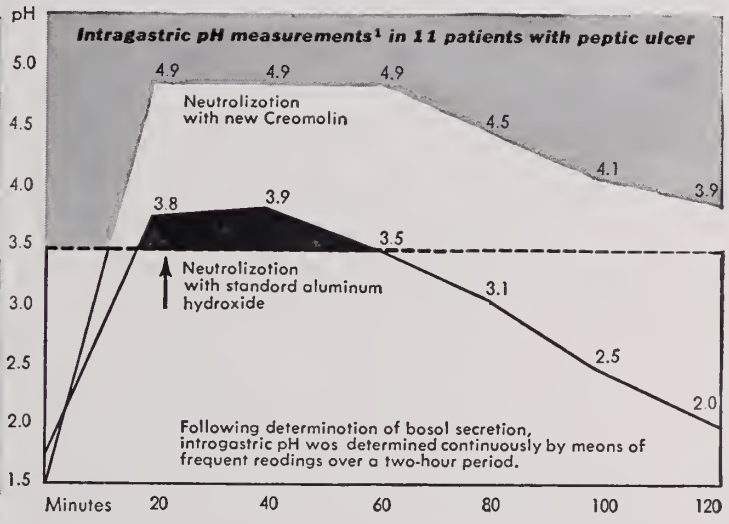
In evaluating the Conferences, a staff member of the Division of Chronic Diseases of the U.S.P.H.S. stated that they were informative, practical, and designed to save lives through the refocusing of attention on lesions of the oral structures.

**This article was prepared by E. B. Gernert, D.M.D., M.P.H., Associate Director, Division of Dental Health, Kentucky State Department of Health, Frankfort, Kentucky.*

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Q.—How soon after a member leaves his group is he sent a bill for dues so that his Blue Shield may be continued on a direct basis?

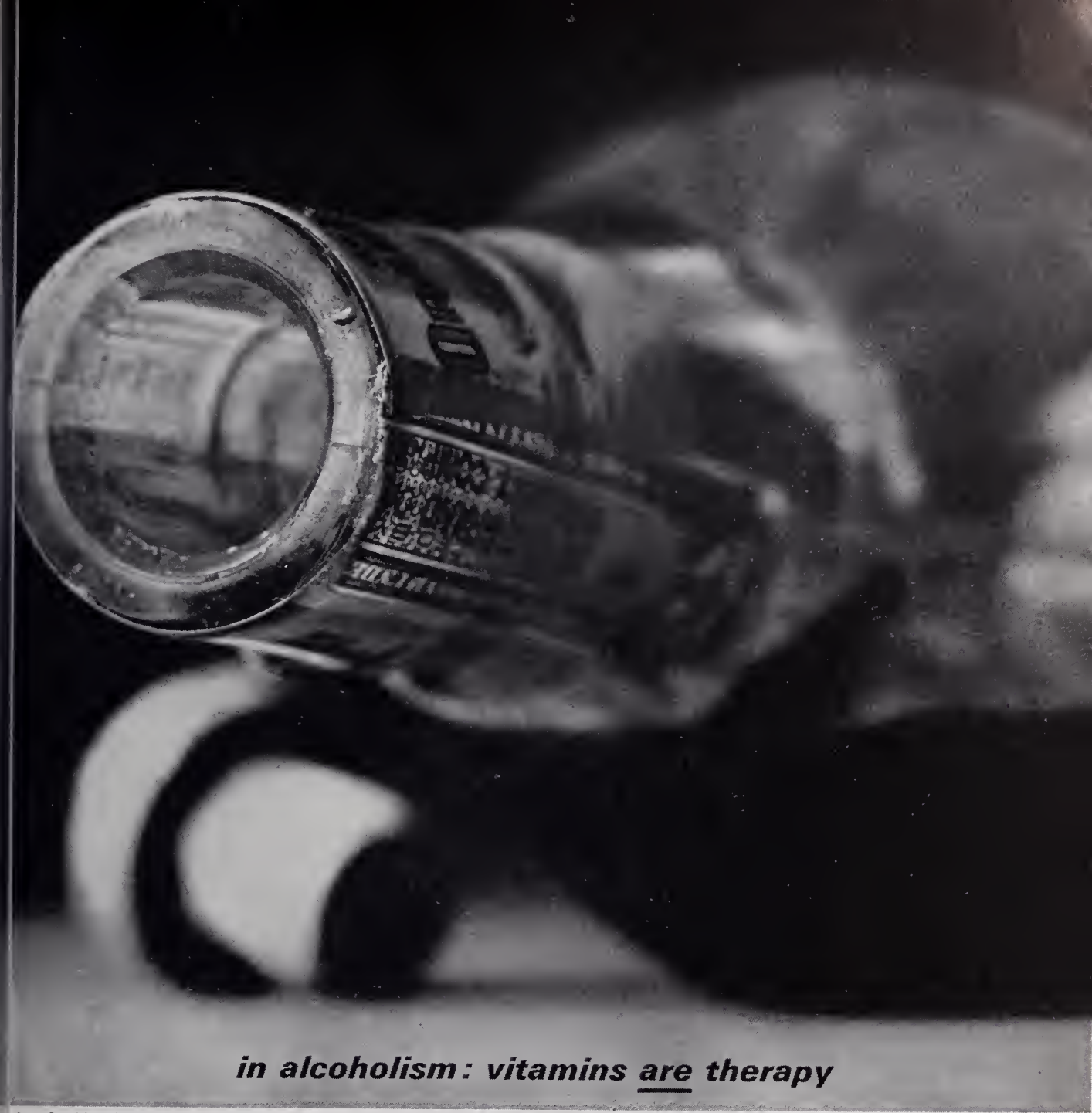
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New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

Codeine phosphate 15 mg.—to relieve local and generalized pain and control dry cough

Neo-Synephrine® 10 mg.—to shrink nasal membranes and open sinus ostia

Acetylsalicyclic acid 300 mg. (5 grains)—to reduce fever and relieve aching

Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

Winthrop LABORATORIES
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*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

1551M



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

© Florida Citrus Commission, Lakeland, Florida



sausage? a problem for your gallbladder patient

For gallbladder patients Entozyme may provide significant relief from the discomforts of fat-induced indigestion. Just six Entozyme tablets (the usual daily dose) digest sixty grams of fat—or more. That's as much as 50 to 90% of the normal daily intake of average adults.

The reason for Entozyme's fat-digestion potency is that each tablet contains 150 mg. of Bile Salts and 300 mg. of Pancreatin, N.F. (in an enteric coating). Bile Salts stimulate the flow of bile and enhance the lipolytic activity of both Entozyme's Pancreatin and the patient's own lipase. Together Bile Salts and Pancreatin greatly aid the emulsification and transport of fat.

Entozyme also contains Pepsin, N.F., 250 mg., which facilitates the breakdown of protein.

A. H. Robins Company, Inc., Richmond 20, Virginia

entozyme® a natural digestive supplement



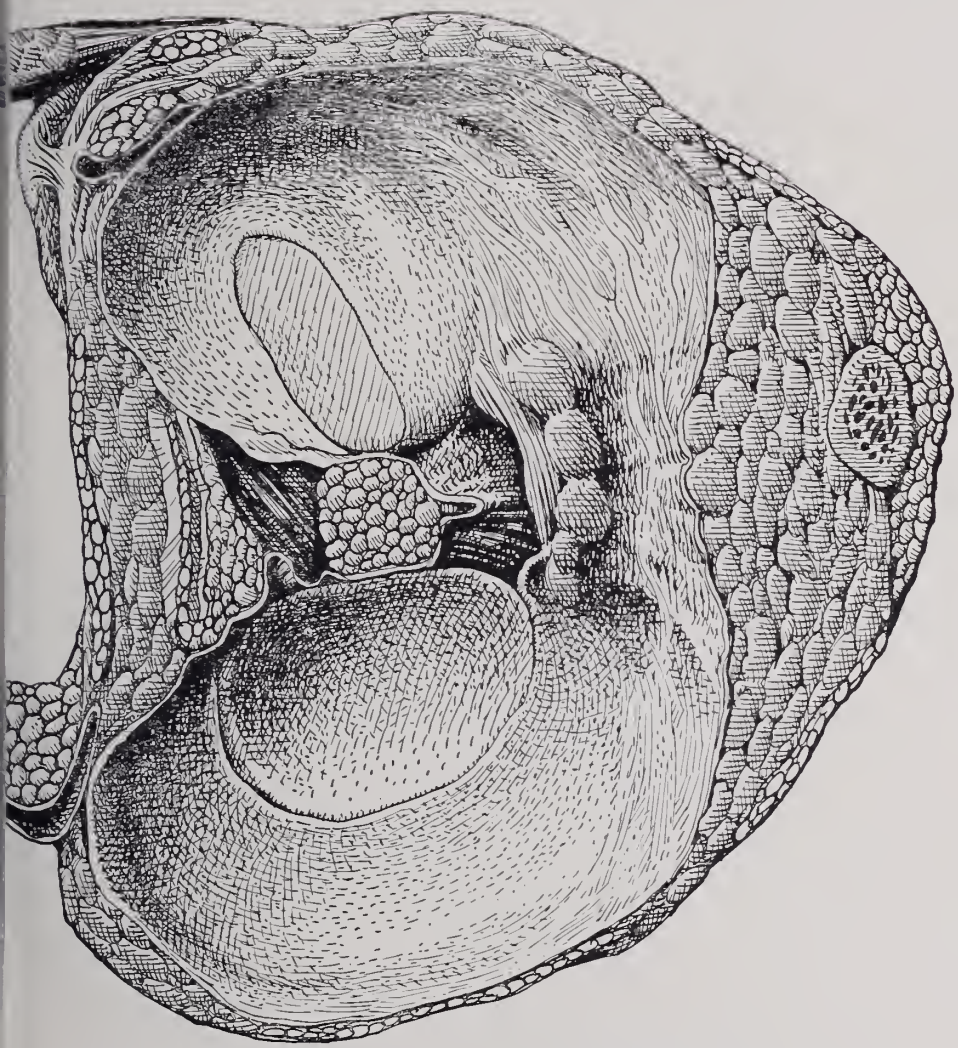
because patients are more than arthritic joints... controlling inflammatory symptoms is frequently not enough

Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheuma toid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whol patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for th symptom may also be bad for the patient.

Unsurpassed "General Purpose" and "Special Purpose" Corticosteroid...
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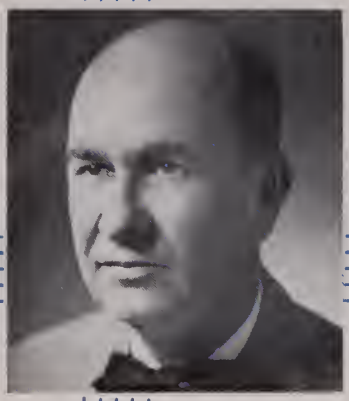
(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

ARISTOCORT is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

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MESSAGE FROM THE PRESIDENT

What Is The Hour?

THE NASA placed a man in orbit recently, a truly remarkable complex feat—yet, we as a nation continually fail to balance our fiscal budget. Would it be possible as a nation to live within our income if we tried as earnestly as the astronauts did at their task? Is this deficit spending becoming "old hat" with us, and are we to continue to increase the national debt which now stands at three hundred billion dollars to a totally unrealistc figure?

In 1812, Kentucky petitioned the Congress for matching federal funds to build a road from Maysville to Lexington, Kentucky, and was refused. In the 1830's Congress appropriated the funds at the second request, but President Jackson vetoed the measure. Now we demand federal matching funds for all kinds of projects and a willing Congress often obliges. Many candidates make fantastic promises of federal asistance to groups through Social Security or otherwise, or to inhabitants of communities who wish matching funds for local projects in return for voter support, thus both the citizen and the legislator contribute to this fiscal irresponsibility.

If we are to regain solvency, we must, as thoughtful voters with a sense of economic responsibility, cease to request such appropriations from the U. S. Treasury and we must demand and receive from our legislators and the executive branch of the government sound and acceptable fiscal practices. All expenditures, unless absolutely essential, should be curtailed, or totally avoided, until such time as the national defense cost can be reduced liberating more funds for other purposes. This change can be achieved only if we select and support conservative candidates—the party label is meaningless—it is rather late!

D S Simpson



Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

*Warning—May be habit-forming.
Subject to Federal Narcotic Regulations.

No. 1 — gr. ⅛
No. 2 — gr. ¼
No. 3 — gr. ½
No. 4 — gr. 1

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



A Counter Proposal to H. R. 4222

IN A recent editorial, the Saturday Evening Post severely castigated the American Medical Association because of the AMA's opposition to the President's program for furnishing health care to the aged through the Social Security approach.

There were several misrepresentations and even absolute untruths in the accusations which were made against the AMA. The editorial went so far as to claim that, "Doctors, as a group, have in essence been against almost everything that America is for."

Counter Proposal Suggested

The editorial concluded, however, with the statement that, "we certainly would be with them (the doctors) if they came up with a counter proposal, acceptable to doctors, that would do the job the President envisages."

At the very time the editorial was being prepared for publication, the AMA and the National Association of Blue Shield Plans came out with their joint announcement of a uniform nationwide Blue Shield medical care prepayment program for persons 65 years of age or older, with uniform premiums and uniform benefits throughout the nation.

AMA Resolution

In its formal resolution endorsing this program, the AMA Board of Trustees pointed out that the program conforms to the spirit of the Policy adopted by the AMA House of Delegates in December 1958, which urged the immediate development of prepayment plans for older people of limited income and resources at premium rates which these people could afford.

The AMA Board's statement also recommended that all constituent medical societies take such action as is necessary to cooperate with the new Blue Shield program.

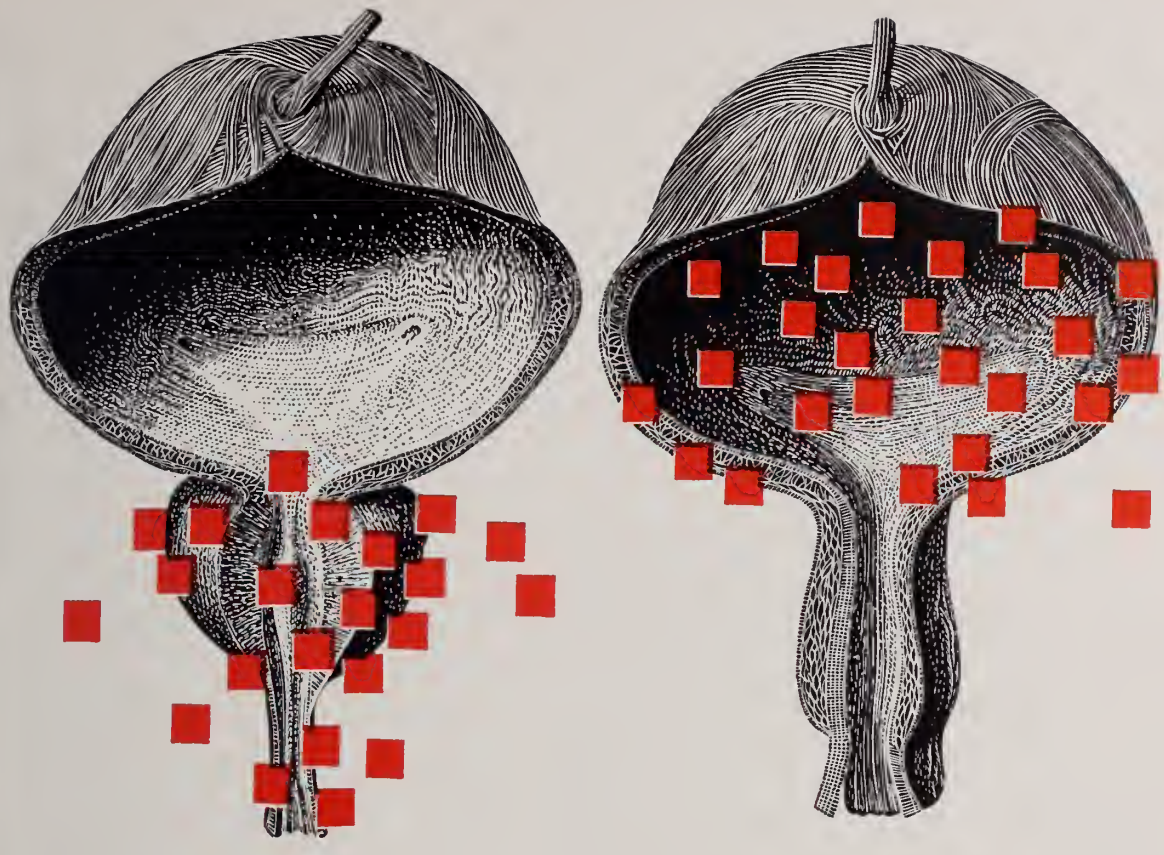
Newspaper response to the announcement has been overwhelmingly favorable. Typical of the editorials was that of the Chicago Daily News which said bluntly that, "On any basis of logic, the proponents of the Administration's Social Security plan for Old Age Medical Care would be hard put to demonstrate that program's superiority to the one introduced by the Blue Shield Plans."

Timing Is Good

The timing of this program is especially fortuitous as all of our Congressmen are under heavy pressure from many sources to support the Administration's Social Security approach to the health care of the aged. We can now, even more than before, show our legislators that voluntary prepayment for the health care of our senior citizens is available and that it is effective and that the Social Security approach to this problem is neither necessary nor desirable.

Failure of any of our state medical associations to implement this plan with all possible haste, would mean that they would lose, by default, the psychological advantage of the best counterproposal yet presented against the King-Anderson and similar measures.

W. Vinson Pierce, M.D.



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Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

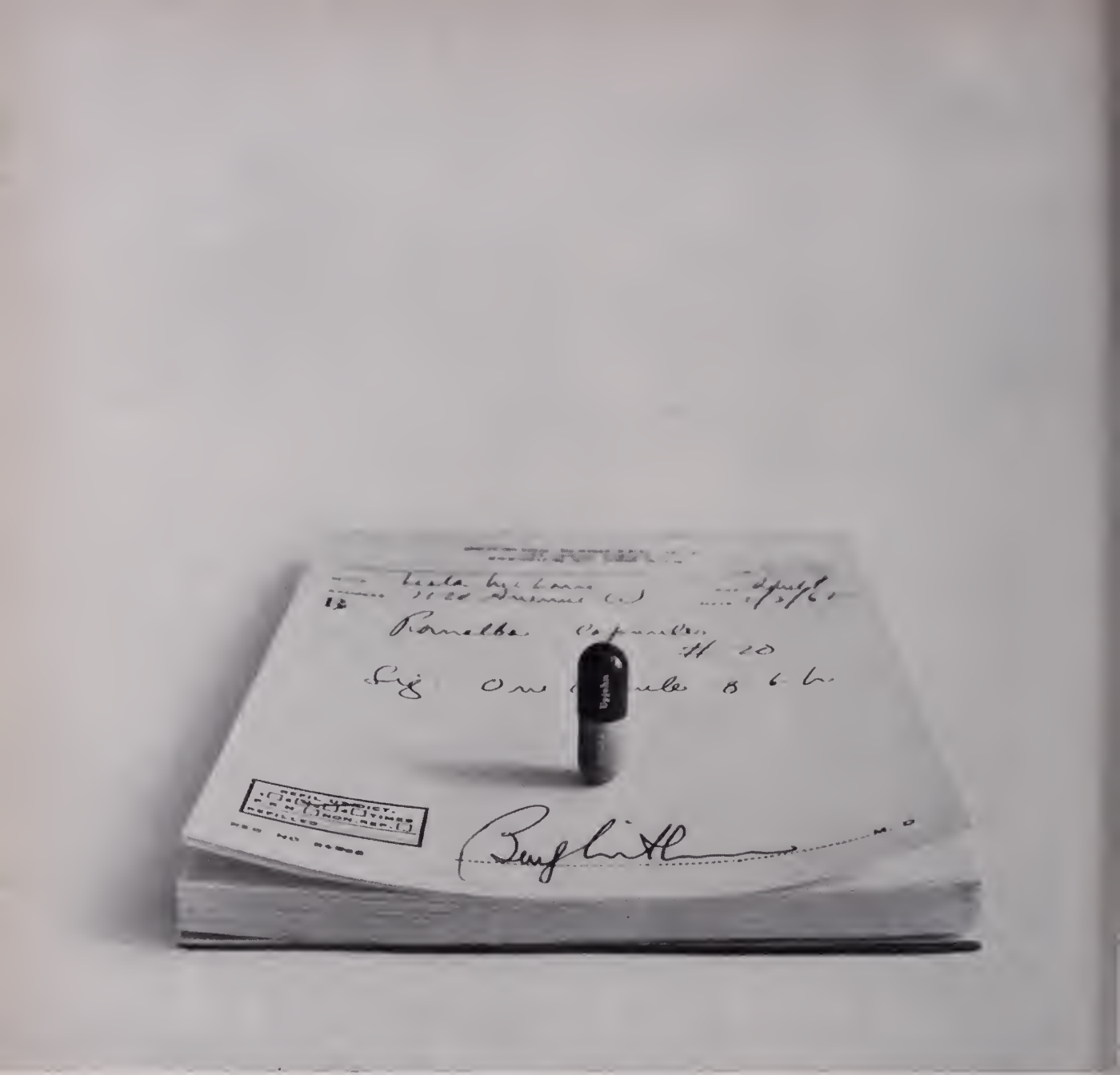
Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

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Launching Pad

In infections of unknown etiology, prescribe Panalba. From the outset, pending laboratory determinations, your treatment is broadened in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most infections of unknown etiology, Panalba offers excellent chances for therapeutic success— and why it should be your antibiotic of first resort.

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Kalamazoo, Michigan

Panalba* product information

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Usual Adult Dosage: 1 or 2 capsules three or four times a day.

Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U. S. PAT. OFF.

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DECEMBER, 1961

THIS DOCTOR

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- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

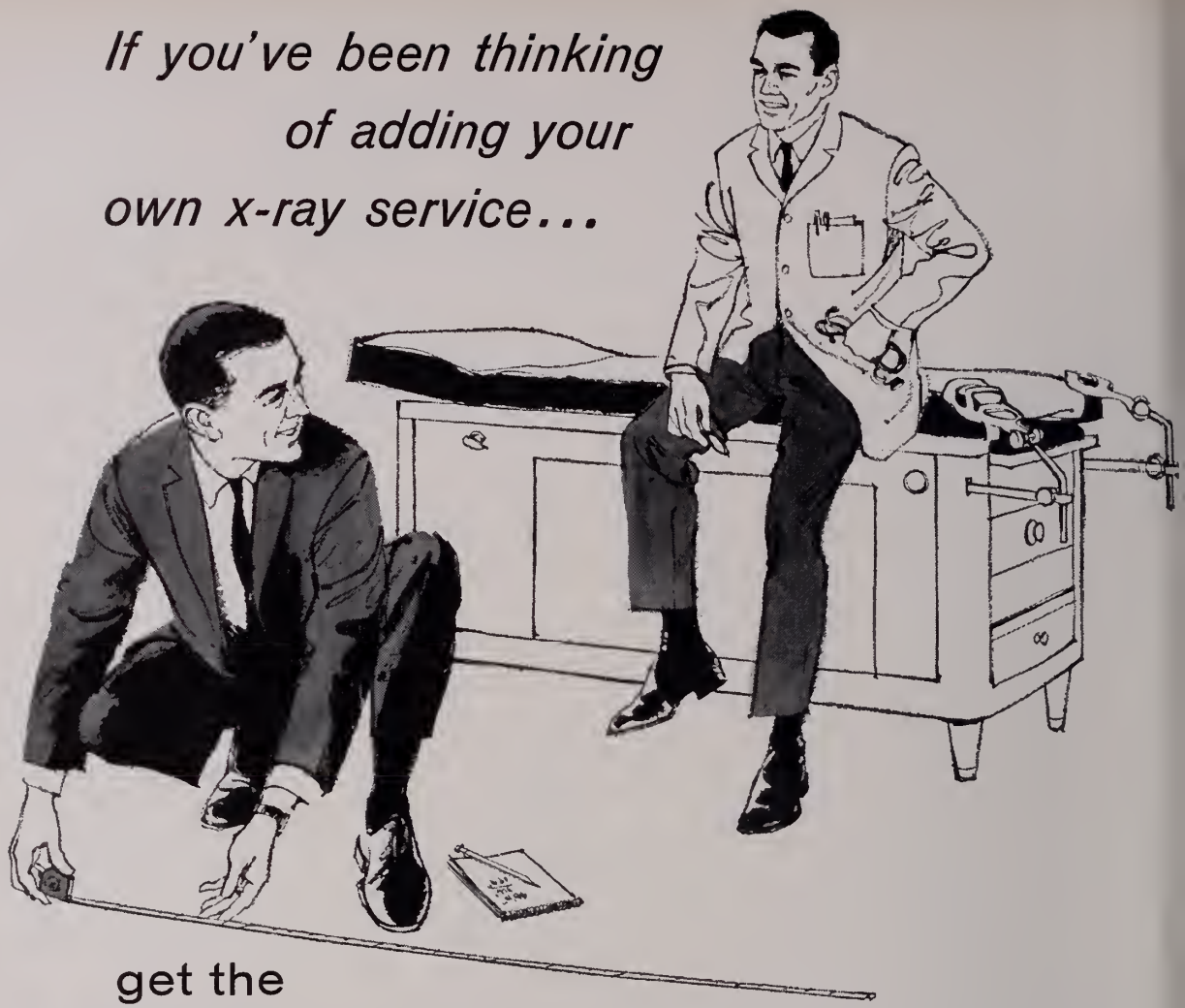
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If you had to make your own children's multivitamins

...chances are you'd try to make them very much like our new Vi-Daylin® Chewable with Entrapped Flavor. Entrapped Flavor means a better tasting chewable children's multivitamin; one with no vitamin aftertaste. Here's why: 1. We coat all the vitamins in a digestible film that does not dissolve until it reaches the gastrointestinal tract. This means that unpleasant strong vitamin tastes are not released in the mouth, but in the g-i tract where they are most quickly absorbed. 2. We make certain that every Vi-Daylin Chewable tablet tastes citrus sweet and good to every patient, everytime; we coat the flavoring oils in each tablet in a water soluble film. This film dissolves immediately in the mouth, releasing the full bouquet of our citrus-candy flavoring agents. Now you know why little patients always taste the flavor, never the vitamins, when you prescribe new Vi-Daylin Chewable. And the formula's all you'd expect, with reasonable amounts of A & D. Taste test them yourself and you'll prescribe **VI-DAYLIN CHEWABLE** regularly and soon.

ABBOTT

Profile of a multivitamin



New Vi-Daylin Chewable —with entrapped flavor

New Formula

In recognition of recent medical thinking, we've reduced the vitamin D in our formula from 20 mcg. (800 units) to 10 mcg. (400 units). At the same time, we've increased the vitamin C content from 40 mg. to 50 mg. per tablet and per 5-cc. lemon-candy teaspoonful.

All Other Elements Remain at Their Previous Level.

Vitamin A (3000 units)	0.9 mg.
Thiamine Mononitrate	1.5 mg.
Riboflavin	1.2 mg.
Cobalamin (B_{12})	3 mcg.
Nicotinamide	10 mg.
Pyridoxine Hydrochloride	1 mg.

New Low Price

In quantities of 100 tablets our new Chewable costs less than 4¢ a tablet and the normal dosage is one tablet daily. No financial hardship for your patients when you prescribe or recommend Vi-Daylin.

New Shape, New Color, New Bottle

New Vi-Daylin Chewable tablets are football shaped. This shape got a high degree of acceptance in our taste-tests and seems to have an intrinsic interest for children. The orange color ties in with the mild, sweet citrus flavor. And the wide-mouthed new bottle looks handsome on the table.

Taste-Test New Vi-Daylin Chewable Yourself

Won't you taste-test new Vi-Daylin Chewable multivitamins yourself? We're certain you'll be pleasantly surprised at their sweet good taste. They're the candy-flavored multivitamins with *entrapped flavor* . . . little folks taste the candy flavor, never the vitamins.

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for more satisfactory relief of anxiety-aggravated pain

PHENAPHEN®

- More satisfactory than "the usual analgesic compounds" for relieving pain and anxiety.[1]
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Each PHENAPHEN *capsule contains:*

Acetylsalicylic acid (2½ gr.)	162 mg.
Phenacetin (3 gr.)	194 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Also available:

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PHENAPHEN with CODEINE PHOSPHATE
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Bottles of 100 and 500 capsules.

1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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WASHINGTON NEWS DIGEST



WASHINGTON, D.C.—The American Medical Association again endorsed a legislative proposal that the federal government help finance construction of new medical schools and expansion and modernization of existing ones.

Gerald D. Dorman, M.D., of New York City, a member of the AMA Board of Trustees, told the House Interstate and Foreign Commerce Committee:

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools, and, therefore, a one-time expenditure of federal funds on a matching basis is justified, where maximum freedom of the school from federal control is assured."

Doctor Dorman was presenting the AMA position on the Kennedy Administration's 10-year, $932,000,000 program (H.R. 4999) for federal aid to medical education. The legislation also proposed scholarships for medical and dental students.

"If the high standards of medical education are to be maintained, increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education," Doctor Dorman said. "Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. At this time, priority should be given to an increase in the physical facilities available for medical education."

Doctor Dorman said the AMA had not taken a position on the other sections of H.R. 4999. However, he reviewed related AMA programs.

"For some time, the AMA has been aware of the decline in the number of eligible college students seeking admission to medical schools," he said. "This apparent shift away from medicine is due, in part, we believe, to the high cost in time and money of securing a medical education. This trend has been accentuated by a dramatic emphasis on careers in science and engineering.

"The House of Delegates of the AMA in November 1960 established two programs, the objectives of which are complementary and interrelated.

"First, the House authorized a student honors and scholarship program designed to focus attention on careers in medicine, to attract a substantial group of able students to prepare for admission to medical schools and to assist financially a limited number of outstanding students who, for financial reasons, are unable to pursue a career in medicine.

"Second, the AMA House of Delegates has adopted a student loan program designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine."

Doctor Dorman also pointed out that the AMA in the past 10 years, in collaboration with the Association of American Medical Colleges, had aided interested organizations in the establishment of six medical schools.

"Currently, commitments have been obtained for another five schools and we are in consultation with 16 institutions or organizations presently contemplating the establishment of new medical schools," he added.

Action Called Irresponsible

The AMA said it would be irresponsible to combine the King-Anderson bill with legislation that would permit physicians and other self-employed persons to defer income tax on income placed in specified private retirement funds.

Senator Clinton P. Anderson (D., N.M.), co-author of the King-Anderson bill which would provide limited health care for aged persons under Social Security, suggested the combining tactic during a televised debate on the medical care issue with Senator John Tower (R., Tex.).

The private retirement legislation—H.R. 10, the Keogh bill—would extend to an estimated 11,000,000 self-employed and their employes the same tax benefits now provided to about 20,000,000 wage earners covered by 66,000 company pension plans.

"This 'doubling-up' proposal of Senator Anderson certainly proves the insincerity of the King-Anderson bill," F. J. L. Blasingame, M.D., executive vice-president of the AMA, said. "It lays bare the fact that this is wholly a political issue and not a sincere attempt to grant meaningful medical care for the aged.

"It would be an irresponsible bit of legislative sleight of hand to combine Senator Anderson's proposed compulsory medical care program with a bill to eliminate tax inequities inflicted on the self-employed.

"Such unwarranted action could only serve Senator Anderson's own political ambitions at the expense of millions of Americans.

"The bills have nothing in common. There is no reason whatsoever for combining them except that Senator Anderson is attempting to harrass critics of his bill into silence.

"He even calls the Keogh bill the 'doctors' special pension program', ignoring the fact that doctors make up only about 2.6% of those self-employed who would be getting the tax equity."

The Keogh bill has received widespread bi-partisan support in both Houses of Congress. It was passed by an overwhelming vote in the House last summer and cleared the Senate Finance Committee by a 13-3 vote.

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Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS®—400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

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Secran provides a combination of hematopoietic vitamin B_{12}* with appetite-stimulant vitamin B_1**, plus roborant vitamin B-complex.

Anemic patients on this therapy show increased red blood cell counts, improved appetite, higher hemoglobin levels, and satisfactory weight gains.

Each average teaspoonful (5 cc.) contains the five following B-Complex vitamins in a palatable vehicle:

Vitamin B_{12} Crystalline	25 micrograms
Thiamine Mononitrate (vitamin B_1)	10 mg. 10 MDR
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*NEW AND NONOFFICIAL DRUGS, 1959, p. 644.
**DUNCAN'S DISEASES OF METABOLISM, 4th ed., 1959, page 142.



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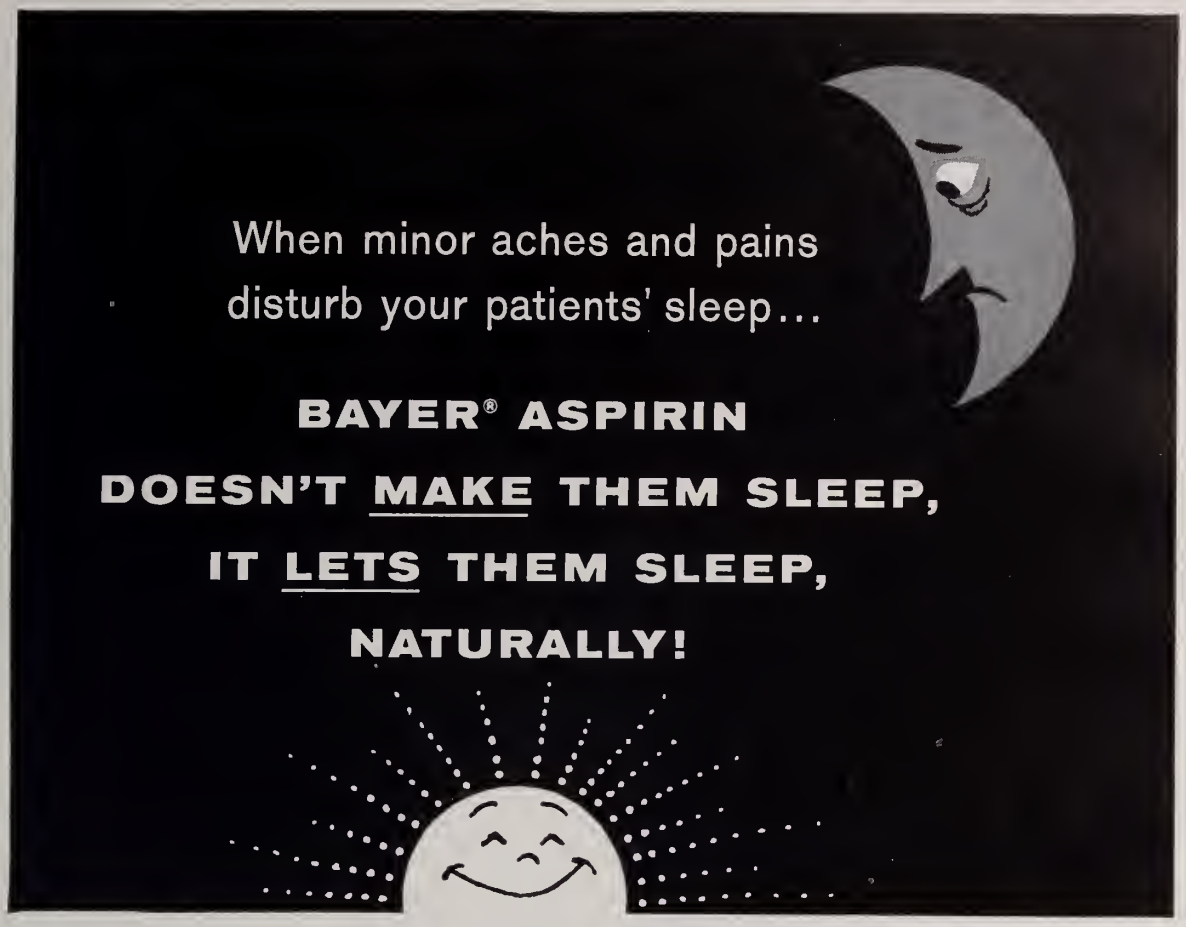
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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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Abraham Lincoln—A Medical Appraisal*

ABRAHAM M. GORDON, M.D.
Louisville, Ky.

Abraham Lincoln was tall, loose-jointed, kyphotic, dolichocephalic, with unnaturally long, thin, arms and legs. The Marfan Syndrome, presumably inherited from his mother, is believed to explain Lincoln's morphological appearance.

THIS year, 1961, marks the centennial of the American Civil War, considered by most historians as the greatest ordeal in our existence as a nation. To honor this occasion Congress created a Civil War Centennial Commission to provide for appropriate and nationwide ceremonies in remembrance of those stirring events and determined men of 100 years ago. Many able and gifted individuals laboured and fought on both sides in this great ideological conflict, and out of a handful of men worthy of mention, Abraham Lincoln attained a place in our history unequalled by any American, excepting the Founding Fathers of the American Revolutionary War. His character and personality have captured the imagination of generations of men throughout the civilized world and here at home he has become part of the American legend. Lincoln was endowed not only with unique traits of mind and spirit but was also blessed with a peculiar and unusual physical appearance. It is his physical defects that have interested me for some time and I shall present the results of my investigation of their origin and classification.

Before recreating Lincoln's image I would like to read from a letter, written in 1887 by William Herndon, Lincoln's intimate friend and biographer, "You may show my letters to your best physicians, physiologists, histologists, anatomists, etc., but they—my letters—are otherwise private. Please get your learned men to assist us. The idea is worthy of an opinion from science. The precise inquiry would be this: Was Lincoln's organization, as compared with other men, of a low order and was it of a low order when Lincoln was looked at by himself and not compared with other men." Herndon had long been puzzled and perplexed by Lincoln's appearance and sought an explanation from the learned men of his day. He continues, "If I were you I would consult some of the best of Boston's physicians on this very question . . . If your physician gives you an opinion, please write to me." Herndon's question was never answered and no explanation of Lincoln's deformities has ever appeared according to the Lincoln scholars that I have consulted.

What was he like—this strange man from Illinois, elected to the high office of the Presidency? Of necessity his description is based on the written testimony of his contemporaries. It is remarkable how well they agree in their

*Presented at the meeting of the Kentucky Chapter of the American College of Physicians during the 1961 KSMA Annual Meeting, September 21, 1961.

description of him. Unfortunately I have not found any record of medical origin describing his physical defects and yet Lincoln suffered his share of minor and annoying illnesses while under the care of several different physicians. The descriptions that I have were written by laymen in non-medical terms but as we shall see they missed little.

Descriptions of Lincoln

The Washington correspondent of the London Times described Lincoln in these terms, "There entered with a shambling, loose, irregular, almost unsteady gait, a tall, lank, lean man, considerably over six feet in height, with stooping shoulders, long pendulous arms, terminating in hands of extraordinary dimensions, which, however were far exceeded in proportion by his feet."

Listen to Edward Dicey, a well known writer and biographer of that day, "Fancy a man six foot high, and then out of proportion, with long bony arms, and legs, which somehow seem to be always in the way, with large rugged hands, which grasp you like a vise when shaking yours, with a long scraggy neck, and a chest too narrow for the great arms by its side, add to this figure a head cocoa nut shaped and somewhat too small for such a stature, covered with rough, uncombed and uncombable, lank, dark, hair, that stands out in every direction at once; a face furrowed, wrinkled and indented, as though it had been scarred by vitriol, a high narrow forehead; and sunk beneath bushy eyebrows, two bright, somewhat dreamy eyes that seem to gaze through you without looking at you; a few irregular blotches of black bristly hair in the place where beard and whiskers ought to grow; a close-set, thin lipped, stern mouth, with two rows of large white teeth, and a nose and ears, which have been taken by mistake from a head twice the size."

The picture that emerges is that of an Ichabod Crane or an El Greco painting come to life.

Nathaniel Hawthorne, on a visit to the White house, writes, "There was a stir on the staircase and in the passageway, and in lounged a tall, loose-jointed figure . . . It was impossible not to recognize Uncle Abe. There is no describing his awkwardness, nor the uncouthness of his movements."



Figure 1. This picture of Lincoln was made in 1846, when he was 37 years old. Exhibited are these features found in the Marfan Syndrome: dolichocephaly, dolichostenomelia, large ears and hands. Notice the loose-jointed and abnormal position of the ring and small fingers of the left hand. Prognathism is prominent and the facial expression is sad. The eyes are small and deeply placed in his head. The face is asymmetrical. The fingers appear exceptionally long; the hands are massive (Lincoln wore a size 10 glove). (From the Frederick H. Meserve Collection.)

Princess Salm-Salm writing in her memoirs recorded this picture of Lincoln, "He was tall and thin, with enormously long loose arms and big hands, and long legs ending with such feet as I never saw before; one of his shoes might have served Commodore Nutt as a boat . . . He had very large ears standing off a little, and when he was in a good humor I always expected him to flap with them like a good natured elephant."

The most complete description of our subject appears in the work by William Herndon, Lincoln's law partner, biographer and friend of 25 years. He writes, "Mr. Lincoln was six foot four inches high, and when he left the city of his home for Washington 51 years old, having good health and no gray hairs, or but few on his head. He was thin, sinewy, rawboned, thin through the breast to the back, and narrow across the shoulders; standing he lean-



Figure 2. This is the appearance of a patient suffering from the Marfan Syndrome. At 24 years of age he died of a dissecting aneurysm. Compare this photograph with that of Lincoln. The hair color and texture are much alike. The ears are also large and appear malformed. Prognathism is less marked in this patient than in Lincoln. Pectus excavatum is marked. Notice the "narrow shoulders and thin chest" so like Herndon's description of Lincoln's chest (see text for Herndon's description of Lincoln). Kyphosis is present as is dolichostenomelia. The head is dolichocephalic and the facial expression sad. Admitted to the Medical College of Virginia in 1949, no mention of abnormalities within the eyes was found in the case report. If Lincoln is descended from "a nobleman so-called of Virginia . . . My mother inherited his qualities and I hers," (Herndon) might not this Virginian be a descendant of the same Virginia stock that produced Lincoln? The rarity of this disorder in the population at large makes this supposition entirely possible. (From McKusick, V. A.: Circulation II: 321,1955.)

ed forward—was what maybe called stoop shouldered, inclining to the consumptive build. His usual weight was 180 lbs. His organization, rather his structure and function worked slowly. His structure was loose and leathery; his body shrunk and shrivelled; he had dark skin, dark hair and looked woe-struck. The whole man, body and mind worked slowly, as if it needed oiling . . . When he walked he moved cautiously but firmly; his long arms and giant hands swung down by his side. He walked with even tread, the inner sides of his feet being parallel. He put the whole foot flat down on the ground at once, not landing on the heel; he likewise lifted his foot all at once, not rising from the toe, and hence he had no spring to his walk. His walk was undulatory . . . His legs and arms were abnormally, unnaturally long and in undue proportion to the remainder of his body. It was only when he stood up that he loomed over other men. Mr. Lincoln's head was long and tall from the base of the brain and from the eyebrows. The size of his hat measured at the hatters block was seven and one-eighth, his head being from ear to ear six and one half inches, and from front to the back of the brain eight inches. Thus measured it was not below medium size. His forehead was medium but high; his hair dark almost black and lay floating where his fingers or the wind left it, piled up at random. His cheek bones were high, sharp and prominent; his jaws were long and curved upward; his nose large, long, blunt and a little awry toward the right eye. His chin was sharp and upcurved, his eyebrows cropped out like a huge rock on the brow of a hill; his long sallow face was wrinkled and dry, with a hair here and there on the surface; his cheeks were leathery, his ears large, and ran down almost at right angles from his head; his lower lip was thick, hanging and undercurved, while his chin reached for the lip, upcurved; his neck was neat and trim, his head being well balanced on it; there was a lone mole on the right cheek, and an Adam's apple on his throat.

Deformities Listed

This description by Herndon I asked an orthopedist to read with the request that he enumerate all orthopedic deformities described by the writer. This he did and I shall list them for you later.

Dan Vorhees of Indiana when asked to describe the President, said of Lincoln, "Lincoln is lean and lathy; his long rake handle arms are strong as steel; he stoops a little, is angular, a man of bony corners . . . Even when he crosses his SPIDERLIKE legs or throws them over the arms of a chair he does it with a natural grace."

To summarize these various descriptions of Lincoln, recorded by his contemporaries, an image emerges that is tall and thin, with unnaturally long loose arms and legs. The cartoonists of his day capitalized on these aberrations by showing Lincoln as an ape-like creature with his great arm spread measure-

ments and bent by kyphosis. In addition he was loose-jointed, dolichocephalic and probably had a highly arched palate. He was flat footed, kyphotic, with large hands and feet, long stringy musculature and scant subcutaneous fat. His ears were large and malformed, his eyes small and deeply placed in his head. A chest deformity, prognathism and genu recurvatum is suggested in Herndon's description. These findings to me suggest the diagnosis of the Marfan Syndrome. Is this diagnosis tenable in Lincoln's case? I believe that it is and I shall now marshall all the evidence that favors this diagnosis.

The Marfan Syndrome

The Marfan Syndrome or Arachnodactyly, as the disorder is sometimes named, is a heritable disease of connective tissue manifested in the skeleton, the eye and at times in the cardio-vascular system. First let us examine the heritable basis of this disease in Lincoln's case.

The Marfan Syndrome can appear as a mutation yet in diseases of genetic origin illegitimacy is far commoner than is a mutation. I believe this was true in Lincoln's case. Lincoln himself is the source of this statement according to Herndon: "Billy, I'll tell you something, but keep it a secret while I live. My mother was a bastard, the daughter of a nobleman so-called of Virginia . . . My mother inherited his qualities and I hers." Intellectually as well as physically he appears to have received by inheritance little from his father. Thomas Lincoln was 5 ft. 10 in. tall. He weighed about 190 pounds. He was round faced, good natured and jovial. His body was of stocky build. Lincoln's mother was 5 ft. 8 inches in height; (unnaturally tall for a woman.) She weighed 130 pounds, which means she was of thin proportions. She was never strong. She carried a sad, melancholy facial expression. Unhappily many questions about her appearance remain unanswered. Lincoln recognized and admitted to Herndon his debt to his unknown maternal grandfather and all the evidence points to his mother as the source of his disorder.

Robert Lincoln, the eldest of the Lincoln children was short in stature and like his mother was a "Todd." Edward and William died in childhood. Thomas, who resembled his famous father in his appearance died at 18 years of age from what was called "Dropsy of the Chest." A description of his symptoms suggests the boy was in congestive heart failure. This arouses the suspicion that Tad Lincoln may have developed one of the many cardiovascular complications found in the Marfan Syndrome. In this disease, death of a boy 18 years of age with congestive heart failure is not rare.

A great deal has been written about Lincoln's eyes and yet we know relatively little about them. He suffered with strabismus all his life and at 51 years of age had several attacks of double vision for which no adequate explanation has ever appeared. Unfortunately there were no Ophthalmologists in the United States during his lifetime, so that we know nothing of any defects of the inner eyes that he may have suffered. The science of Clinical Ophthalmology begins with the invention of the Ophthalmoscope by Helmholtz, in the middle of the 19th century. When clinical examination of the inner eye became possible, Ophthalmology was born. Albrecht Von Graefe (1828-1870) became the first Professor of Eye at a German University and described Ectopia Lentis in 1854. Ectopia Lentis, so commonly described in the Marfan Syndrome need not lead to severe visual disability or blindness. Normal eyes have been found in otherwise

	Lincoln	Marfan's Syndrome
Dolichostenomelia	yes	yes
Dolichocephaly	yes	yes
Ectopia Lentis	no?	yes (50-70%)
(Strabismus)	yes	yes
Cardiovascular (Tad Lincoln)?	no	yes (20-30%)
Gothic palate	yes	yes
Loose jointed	yes	yes
Chest deformity	Probable	yes
Large hands and feet	yes	yes
Hernia	unknown	yes
Pes planus	yes	yes
Kyphosis	yes	yes
Muscular Hypotonia	no	yes (10-15%)
Cleft palate (Tad Lincoln had a cleft palate)	no	yes
Misshaped Pinnae	yes	yes
Subcutaneous fat	scant	scant
Prognathism	yes	yes
Facial Expression	sad	sad

Figure 3. Here is listed Lincoln's physical defects as described by Herndon and a comparison is made with their incidence in the Marfan Syndrome. All eye defects have been lumped together under ectopia lentis. At 47 years of age he purchased a pair of "specs" that corrected his vision with lenses of 6.75 diopters. At his age, only 2.5 diopters is generally needed for correction. The evidence weighs heavily in favor of this diagnosis in Lincoln's case.

classical cases of the Syndrome. McKusick states it very well when he writes, "In this disease (Marfan's Syndrome) anyone of the 3 major components (skeletal, ocular or cardiovascular) may be present with little or no involvement in the other two areas."

As far as is known Lincoln was free of cardiovascular disease at the time of his death. Tad Lincoln's fatal illness has already been referred to.

The spoken voice in patients with Marfan's Syndrome is often high pitched with a characteristic timbre. One author believes he can recognize affected persons on the telephone by their speech. Lincoln is said to have had a high pitched tenor voice, almost girlish in quality. Facial asymmetry is often described as part of this syndrome. Conant, who painted Lincoln in 1860, complains of his difficulties, faced as he was by Lincoln's asymmetrical countenance.

A word about the differential diagnosis in this disorder and from the facts already presented each of these entities can be ruled out. These include,: 1. The Klinefelter Syndrome 2. The Eunuch 3. Sickle Cell Anemia 4. The Denker Negro.

I titled this paper a medical appraisal of Abraham Lincoln and yet a great deal about Lincoln of medical interest I have not included in this report. I have attempted to show, based on information gathered from many different sources, that Lincoln exhibited the skeletal derangements classically associated with the Marfan Syndrome. I have shown that a genetic basis for this disorder in Lincoln's case exists and even without benefit of an eye examination I find this diagnosis still tenable. I believe that many things about Lincoln not previously understood can now be comprehended if the Marfan Syndrome is given due consideration. In 1887, William Herndon, sought an answer to this question: Why and how Lincoln differed from other men? In 1896, thirty one years after Lincoln's death, Marfan described a child with the skeletal deformities that are now associated with his name. No wonder Lincoln was not recognized for what he was during his lifetime. The Marfan Syndrome is, I believe, established in Lincoln's case by the evidence presented.

The riddle of Lincoln's origin is possibly now soluble. I would search for a Virginia family that carries the stigma of this disease who were probably neighbors to Joseph Hanks, Lincoln's great grandfather. If such a family can be uncovered I believe Lincoln's maternal grandfather will be found among them.

ADDENDUM: This work has been revised for publication in the Lincoln Herald and is in press. As time was limited, many details about Lincoln and the Marfan Syndrome could not be included in the address.

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Cancer Detection And Therapy of The Female Pelvis*

Henry B. Turner, M.D.
Memphis, Tenn.

Detected early and treated directly, the prognosis in pelvic cancer is fairly good. Five year survival rates should exceed 50% in all but ovarian carcinoma. Results will improve with increased vigilance of both physician and patient.

CANCER detection in the female requires an amazing array of at least six diagnostic tools—a vaginal speculum, a cervical biopsy punch, a curette, a pair of hands, at least one good eye, and an inquisitive mind! One might also add a vaginal aspirating pipette.

In spite of all the laboratory tests, x-rays, Papanicolaou smears and educational programs, our cancer detection is only as good as we, as individual practitioners, make it. Little need to spend millions for cancer research if we haven't yet learned to think of, feel for, and identify carcinoma in its early stages. Contrast, if you will, the cure rate of 50% in a Stage II cervical lesion against a cure rate approaching 100% in an in-situ lesion. The former patient may have enjoyed the optimistic prognosis of the latter had her physician advocated the idea of the annual physical examination and smear.

We all know that the most common sites of malignancy in the female are the breasts and pelvis. Both of these areas lend themselves to examination. It is only in the case of ovarian carcinoma that some difficulty or delay in diagnosis may be experienced. Certainly, in the case of breast, vulval or cervical malignancy, little, if any diagnostic delay should occur.

Let's discuss in more detail some of the diagnostic problems that arise in the diagnosis of pelvic malignancy. At the same time, we will outline our present therapeutic approaches in use in the Division of Obstetrics and Gynecology at the University of Tennessee in Memphis.

Carcinoma of the Vulva

Apparently most physicians have the opportunity to see very few cases of vulval malignancy. I say this because I firmly believe that this is the poorest managed of all pelvic cancers—both from a diagnostic and a therapeutic point of view.

Diagnostic failures may result from the fault of the patient or the physician. The patient most frequently errs by not seeking early treatment for chronic vulval pruritus (leukoplakia) or she persists in the treatment of a "little sore." The physician is sometimes guilty of depreciating the significance of hyperkeratosis (leukoplakia) or is reluctant to biopsy the labia.

Therapeutically, the most frequent errors are made by inadequate attempts at surgical removal of the lesion or by treating the disease by radiation. Successful therapy involves the early use of radical vulvectomy with bilateral inguinal node dissection. Some controversy exists whether or not it is necessary to perform both superficial and deep gland dissection. We tend to agree with McKelvey that removal of the deep iliac nodes adds nothing to the five year survival rate.

In cases adequately treated, the overall five year survival rate is 61%. Cases without node

*From the Division of Obstetrics and Gynecology, the University of Tennessee College of Medicine and the City of Memphis Hospitals. Presented at the meeting of the KSMA First Trustee District, May 25, 1961.

involvement can expect a survival rate of 86%.

Carcinoma of the Cervix

It is in the diagnosis of this lesion that we have been making our best showing in recent years. The Papanicolaou smear should now be available to all women and in localities where it isn't one may well point the finger of blame at the physician. A laboratory where smears may be expertly evaluated is as close as the nearest mail box.

In expert hands, the smear attains an extremely high degree of accuracy. What to do about the positive smear, however, presents a problem. Initially, the first step is a 4 point cervical biopsy at the squamocolumnar junction. Should the diagnosis not then be apparent, repeat biopsy with fractional curettage is indicated. Cold knife conization of the cervix should be reserved for only 3 situations:

1) Diagnosis of the positive smear when other diagnostic steps fail.
2) For the definitive therapy of carcinoma in-situ in the young woman.
3) To rule out invasive carcinoma prior to initiating definite therapy for in-situ carcinoma.

Therapy for non-invasive carcinoma is deep conization of the cervix if further reproduction is a factor. If an adequate family exists, the correct therapy is total hysterectomy by the vaginal or abdominal route.

Invasive carcinoma of the cervix, we feel, is best treated radiologically. Wertheim hysterectomy is no small undertaking and even in experienced hands is reserved for patients with Stage I lesions who are good operative risks and for certain cases of radiation recurrence.

Endometrial Carcinoma

The curette is the instrument that makes the diagnosis of endometrial carcinoma. Curettage must be carried out in all cases of postmenopausal bleeding. In addition, more cases of menorrhagia in patients 40 years of age or over should be treated initially by curettage.

The Pap smear will occasionally suggest endometrial carcinoma, but it should not be relied upon for its degree of diagnostic accuracy does not exceed 50%.

There exists a divergence of opinion concerning therapy for endometrial carcinoma. The disease may be treated by surgery, by radiation, or by a combination of these techniques. It has been our custom, for years, to treat our patients initially with intracavitary radium. Four weeks later, we perform a total hysterectomy with bilateral salpingo-oophorectomy.

Ovarian Carcinoma

This is the most insidious cancer of the female genital organs. Occurring most often in women beyond the reproductive era, it is usually asymptomatic in its early growth. The initial symptom may be a pelvic mass, abdominal ascites or, less frequently, postmenopausal bleeding. About 40% of the tumors are bilateral. The only test for its early detection is the annual physical examination! These three points may be of diagnostic value: 1) All adnexal masses larger than 6 cm. in diameter should be removed. This is of increased importance in women 40 years of age or over. 2) All smaller cysts should be checked at monthly intervals and observed for *rapid* growth. 3) Because ovarian carcinoma is sometimes considered a benign uterine myoma, it is probably wise to advocate surgery for all pelvic masses in the menopausal and postmenopausal years.

Treatment of ovarian carcinoma is primarily surgical. Radiation is rarely curative but is frequently employed for palliative purposes. The accumulation of ascitic fluid, for example, is often retarded by cobalt or radioactive gold therapy.

Summary

The early detection of cancer of the female reproductive organs requires that two people be awake—the patient and the physician. Detected early and treated correctly the prognosis in pelvic cancer is fairly good. Five year survival rates should reach 60% or better in vulval malignancy; from 50 to 80% in cervical cancer, and better than 80% with endometrial carcinoma. Only with ovarian carcinoma do we expect less than a 50-50 chance for our patient's survival.

With increased vigilance of the physician and increased enlightenment of the patient, the results will continue to improve.

Clinical Toxicology*

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Both clinical and laboratory data are essential in the diagnosis of chemical intoxications. Without these combined skills, recognition of toxicological phenomena is difficult and may be misleading.

THE study of the effects of poisons on biological tissues has been known for many centuries as the science of toxicology. Historically and traditionally, the development of the fundamental action of poisons was carried out by pharmacologists, biochemists, forensic pathologists and a number of other laboratory investigators. At a time when any poisoning was almost always fatal, these investigators were concerned primarily with matters of chemical identification of compounds and anatomic changes. As scientific skills and laboratory methodology improved, the detailed study of physiologic reactions was pursued. This knowledge led to the realization of two major concepts of toxicology. The first was that death was not always inevitable (since many physiological reactions are reversible) and the second was that the tissue response was related directly to both the dose of the toxic material and the time during which absorption took place. Most of this information was derived from animal experimentation.

Much Information Gathered

As a result of these scientific investigations, much information concerning mode of action, locus of effect and histopathologic change was accumulated. It was inevitable, therefore, that these students of the subject should extrapolate and apply their data to humans with little or no regard for species differences or differential diagnosis. In fact, many of the textbooks (with a few notable exceptions) describe diagnosis and treatment and yet have been written by persons who have never seen a sick patient.

As a consequence of these developments, the clinician in this field has found it necessary to combine the available background of laboratory information with his skill in observation and diagnosis. This combination of experimental data and clinical experience has produced the required background for the medical discipline of clinical toxicology which by definition means the investigation by observation, of disease produced by poisons in the living subject.

Essentials of Diagnosis

As in every medical specialty, the conclusion that we call a diagnosis is the result of direct observation of both the patient's reactions and all the other evidence that appears to have a relationship to the individual's illness. The clinician who is concerned with the effect that might have been produced in his patient by the absorption of a deleterious material utilizes the same type of sequential logical study of the individual and his environment. However, to this background of clinical experience, he must also apply a knowledge of the characteristics of the offending agent plus a knowledge of the type of physiological aberration that can be anticipated. In this fashion, proper management of the illness and an understanding of the prognosis will be assured.

When any exogenous agent is suspected as the etiologic factor in an illness, proper and adequate understanding of the nature of the agent are essential for proper evaluation of cause and effect. This understanding is neither

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vague nor empirical but is based on reasonable and completely understandable fundamental rules of the behavior of chemical and physical agents.

The first of these is the absolute knowledge that the agent in question must have been present and available to the patient in a chemical form, physical state and concentration that made it possible for absorption to take place. This statement suggests, very properly, that absorption of a compound within the body will vary with different compounds of the same element and with different physical forms of the same compound. It further asserts that there must be present, in the environment, an adequate concentration of a material before injury can be produced. It is axiomatic that in a sufficiently dilute concentration any material will be non-injurious. Conversely, in sufficiently great concentrations, even ordinarily harmless substance may become deleterious. For this reason, it is hardly possible to make an intelligent appraisal of a patient's clinical signs, symptoms and reaction without a reasonable understanding of the dose of the material absorbed and the time during which this absorption took place. The basic importance of this quantitative relationship has given rise to the concept that is expressed by the formula: dose x time = physiological reaction.

Definite Facts Considered

This type of reasoning is consistent with our understanding of the action of pharmaceutical drugs and is in accord with basic physiological principles. It considers properly certain definite facts; namely, that most clinical materials produce an immediate and acute illness when absorbed in sufficient quantity, that the effective action of other drugs can be achieved by cumulative doses only and that still others may produce either acute or chronic reactions. Under these circumstances the effects of an etiologic agent that is considered poisonous must be evaluated from the point of view of the effective dose of the material and the time during which the patient was exposed. But in addition, one must know the characteristics of the material that influence its physiological activity.

These characteristics may be many and varied and chemical structure alone may not be sufficient to suggest the ultimate effect on humans. Unfortunately, however, it is common practice to indict a material because of its generic background alone. As a simple example of these principles, one may consider the problems inherent in a diagnosis of lead intoxication.

Lead Intoxication

It is common knowledge that the absorption of lead will produce a very distressing type of illness. Most textbooks will describe the syndrome that is produced by the absorption of lead as characterized by abdominal cramps, nausea, vomiting, obstipation and eventually, peripheral neuritis of varying degrees. The onset of symptoms is slow and progressive. Despite minor variations in quality and degree, of the signs and symptoms, this description is entirely representative of the lead intoxication that may be produced by a variety of inorganic lead compounds. In addition, the diagnosis is confirmed by laboratory reports of increased lead concentrations in the blood and urine—the blood level being the more significant and more directly related to the degree of illness; whereas, the urinary lead reflects the degree and rate of absorption. A description of this type is rather simple and straightforward and it would appear that any question of the diagnosis of lead intoxication could be resolved fairly easily by the application of the foregoing criteria. And this is indeed the case if one bears in mind that this description was predicated on the specific case of the absorption of *certain inorganic* lead compounds.

When appreciable quantities of organic lead compounds are absorbed, however, the patient presents an almost entirely different aspect. The signs and symptoms begin suddenly and almost without warning. When only a small amount is absorbed, the patient may develop twitching, hyperirritability, hyperreflexia, excitability, auditory and visual hallucinations and wild or terrifying dreams. If a greater amount of the material has been absorbed, repetitive convulsions may occur, the patient can become maniacal and death may follow swiftly. An even more interesting and significant difference between these two types of illness is the fact that the blood lead levels may remain rather low. The urinary lead level will be extremely high, however, and will almost directly reflect the intensity of the illness and be a valuable guide

to prognosis. This simple example of the effect of different compounds of the same element is representative of the problems of clinical toxicology that require a reasonable understanding of the precise chemistry of the etiologic agent in any suspected illness.

Chemical Structure

This brief discussion has been predicated on the knowledge that regardless of the basic element in the compound, change in chemical structure will modify physiological reactivity when the compound has been absorbed. The question of absorption itself cannot be taken for granted, however. Again, with reference to the same element, lead, the sulfide of lead is absorbed poorly by biologic tissues and even where there is considerable exposure to this chemical, as in lead mining, lead intoxication is virtually unknown. The reason is obvious. Regardless of the amount of lead sulfide in the environment, absorption has not taken place. Therefore, despite the fact that the lead ion is capable of producing a violent biologic reaction potentially, none can be anticipated unless the compound is absorbable and absorbed.

Physical Form

The chemical structure alone is not the only determining factor in clinical effectiveness, however. Different physical forms of the same compound may produce entirely different types of illness and may have much different loci of action. Here again, a simple example will clarify this basic principle.

Cadmium oxide is a specific chemical compound with a variety of different physiological consequences. One form is a dust and is a bright red pigment, another is produced as the result of the oxidation of finely divided particles of metallic cadmium and a third is in the form of freshly generated fumes at many different temperatures.

These are all properly identified as cadmium oxide. The first (cadmium oxide dust) produces a bright yellow staining of the teeth and, in high concentrations, a minimal amount of fibrous tissue formation in the pulmonary epithelium without symptoms or clinical signs. No physiological dysfunction is evident. The second (finely divided cadmium) may induce a variety of gastro-intestinal disturbances, some kidney dysfunction and a measurable degree of emphysema. These effects develop slowly over a long period of time and cause and effect relationships are difficult to establish. When cadmium oxide exists in the third physical state (freshly generated fumes), an immediate fulminating illness may develop. This is a severe pulmonary reaction with massive pulmonary edema and frequently terminates fatally. The compound was the same in each case, the physical state was entirely different, however, and the diagnosis, treatment and prognosis were obviously dependent upon a clear understanding of the exact nature of the causative agent and a reasonable knowledge of the consequences of exposure and absorption.

This type of evaluation of the character and quantity of a suspected etiologic agent is the first step in the study of any person suspected of having chemical intoxication. But a clear understanding of the substance under suspicion is only a preliminary to a total recognition of a patient's illness. Additional information is required before complete recognition of the disorder can be attained. This information can and must be assembled in an orderly and logical manner in order that the diagnosis will not be made by exclusion.

The Cautious Approach

Haste is never required in making a diagnosis of chemical intoxication. If the patient's illness is acute and of an emergency nature, treatment is directed toward alleviation of the threatening signs and symptoms (as is the case in all medical emergencies). Delay in diagnosis does the patient no disservice and impetuousness may tend to obscure other, more immediate causes of the illness. If the illness is chronic in nature and has existed for a period of time, caution and serious thought of etiology are even more imperative.

With this cautious approach to diagnosis, one can consider the criteria that are necessary in establishing the individual's condition of ill-health and the nature of the causative agent. Basic to such study is the knowledge that the material in question can produce a definite type of syndrome and that the history and clinical signs and symptoms are consistent with the effects that might be anticipated as the consequences of absorption of adequate amounts of the chemical in question. For example, if the patient exhibits a central nervous system dis-

order, one could hardly suspect as the etiologic agent a substance that is not fat soluble and is known not to affect the central nervous system.

Next, in order of importance, is the determination of laboratory data that are related to the effects of the absorption of the material in question. If carbon tetrachloride were the suspected material, one could anticipate the discovery of hepato-renal damage; in the case of absorption of other solvents, however, only the liver would be affected. If heavy metal ions are responsible for the illness, these should be recoverable in either the blood or urine or both. If the compound is known to produce abnormal shadows in the chest roentgenogram, special study must be devoted to x-ray films of this area. The proper and orderly accumulation of these data and their logical interpretation will usually result in an accurate diagnosis.

In addition to these specific principles, there are two others of great value in the assessment of problems in clinical toxicology. The first is that insistent questioning will reveal an adequate history of exposure to the compound (even though the patient himself may not have been aware of exposure) if the onset of symptoms and sequences of daily activity are related properly. It is not unusual that exposure to toxic chemicals may occur in the home, during athletic activities or in the hobby shop.

Finally, but only as a general rule to which there are notable exceptions, when the patient is removed from exposure, he usually begins to improve. There is no doubt that some compounds will induce, in the patient, a steadily downhill course, but the majority of chemicals are eliminated rapidly from the body and improvement is noticeable within a few days after the offending substance ceases to be absorbed.

Summary

The successful management of chemical intoxication is a direct function of the physician's clinical ability, his chemical knowledge and his experience in objectivity. No other specialty offers greater opportunity for logical and orderly study of disease and evaluation of its cause, yet in no other specialty has empiricism been so commonly exercised.

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Transurethral Resection of the Prostate*

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A clinical review of 300 consecutive cases of bladder neck obstruction corrected by transurethral resection of the prostate gland. Statistics as to age, symptomatology and objective findings are presented.

TRANSURETHRAL resection for bladder neck obstruction is a procedure so familiar that one is apt to overlook its relative youth among other common surgical procedures. Although for over 100 years attempts were made to design instruments which could satisfactorily remove obstructing tissue at the bladder neck, the first transurethral resection of the prostate, as we know it today, was not accomplished until 1924. Even then, the vacuum tube used to provide high frequency cutting current was so weak that oil had to be used to distend the bladder.

Vacuum Tube Designed

It was not until 1931 that a vacuum tube generator was designed with sufficient power to cut satisfactorily under water and modern transurethral surgery was begun. It is a tribute to the progress of modern medicine that a highly technical procedure can develop from infancy to skillful application by most urologists within so short a time.

Many will remember, however, that this development was not a smooth progression to its present status. At first, there was immediate and widespread enthusiastic acceptance with the result that many surgeons, and in some instances, even physicians unfamiliar with prostatic surgery, acquired the necessary instruments and generators. It rapidly became evident, however, that the prostatic millennium had not arrived. Surgeons throughout the country discovered that the operation could not be performed with ease, that the technique was difficult to acquire and execute, and that the incidence of morbidity and mortality could be alarmingly high. The resulting reaction to these adverse results caused many recognized urologists to abandon the procedure as unsound. Modern transurethral resection remains a difficult and painstaking operation, but proper training and the refined techniques now available allow its use for the correction of all types of prostatic obstruction with expectation of minimal post-operative morbidity and mortality and uniformly good functional results.

Material and Methods

In reviewing 300 consecutive cases of transurethral resection of the prostate, it was hoped that significant facts could be established concerning age, symptomatology, objective findings and other associated diseases in addition to data more directly related to the surgery itself. Certain constants are present throughout the series and should be mentioned.

Basic laboratory study included a complete blood count and urinalysis, a survey chest film, blood urea nitrogen and in most instances, an intravenous urogram.

The first 150 patients had a pre-operative examination by a consultant in internal medicine who made any additional studies indicated. The last 150 had routine electrocardiograms and medical consultation was requested only when indicated.

Low spinal anesthesia administered by M.D. anesthesiologists was used in all cases.

All operations were done by the same surgeon, using the Iglesias modification of the Nes-

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bit resectoscope. This instrument was designed for use with one hand thus freeing the other for frequent rectal digital control as the resection progresses. This not only provides a safety factor, making perforation of the prostatic capsule unlikely, but also speeds the operation by bringing the adenomatous tissue into a position for more efficient removal.

Bilateral partial vasectomy was done routinely to reduce the possibility of epididymitis.

Cytal was used in all cases as an isotonic irrigating solution, reducing the likelihood of intravascular hemolysis.

Statistical Findings

AGE DISTRIBUTION

50 to 60	—	18	
60 to 70	—	92	75%
70 to 80	—	124	62%
80 to 90	—	49	
over 90	—	3	
Average age	—	71.7	

The average age in this series of patients undergoing transurethral resection was 71.7 years with approximately 75% falling between the ages of 60 to 80 and 62% over 70 years.

DURATION OF SYMPTOMS

Less than 6 mo.	29	
6 to 12 mo.	33	43%
1 to 2 yrs.	66	
2 to 3 yrs.	74	
3 to 4 yrs.	39	
4 to 5 yrs.	29	57%
5 to 10 yrs.	21	
over 10 yrs.	4	

In evaluating duration of symptoms, it should be remembered that because of the age of these patients, many of the histories were of questionable reliability, both in time and degree.
In this series 43% of the patients had symptoms less than two years and 57% had symptoms over two years.

NOCTURIA

0	—	0	
1	—	2	15%
1 to 2	—	14	
2 to 3	—	38	
3 to 4	—	81	
4 to 5	—	62	85%
over 5	—	55	
overflow	—	22	

The usual symptoms of bladder neck obstruction are highly subjective and difficult to evaluate accurately. However, nocturia is a symptom that lends itself to more accurate estimate and can usually be confirmed by a member of the family. This is shown in this series by the fact that all found it necessary to get up at least one time. Approximately 15% from one to three times and 85% three times or more.

RESIDUAL URINE

Less than 60 cc	—	3	
60 to 100 cc	—	57	50%
100 to 200 cc	—	54	
200 to 300 cc	—	21	
300 to 400 cc	—	15	
400 to 500 cc	—	16	50%
500 to 1000cc	—	40	
In retention	—	55	
Average residual 250 cc			

Measurement of the residual urine remaining after the patient has been instructed to empty the bladder as completely as possible, provides a more objective and dependable estimate of the degree of bladder decompensation. In this series, the average residual urine was 250 cc with approximately 50% between 50 to 300 cc and 50% over 300 cc. Those in acute urinary retention were not included in this average.

BLOOD UREA NITROGEN

Less than 15 (nor.)	85	
15- 20	70	85%
20- 30	61	
30- 40	17	
40- 50	11	15%
over 50	9	

The blood urea nitrogen level is a gross indication of overall renal function becoming elevated with renal decompensation or with contributing factors such as dehydration, fever or increased tissue catabolism. As a pre-operative determination, it is used mainly to decide which patients need continued drainage before surgery and which do not. In this series, 34% had normal BUN determination and 85% were less than 30 mgms. per cent.

Of the 300 patients studied, 143 had pyuria on the first examination while 153 patients did not. In four cases, urinalysis reports were missing. In over 90% of those with pyuria, the causative organism was of the coliform group.

Co-existing Disease

After examination and evaluation by the consulting internist, 618 diagnoses other than those related to bladder neck obstruction were made, an average, if you like, of over two medi-

cal diseases per patient. The larger groups were as follows:

CARDIO VASCULAR DISEASE	
Arteriosclerotic CVD	139
Hypertensive CVD	64
Congestive failure	36
Old myocardial infarct	32
Cerebral vascular disease	22
Old cerebral vascular accident	17
Cor pulmonale	3
Thrombophlebitis	6

PULMONARY DISEASE	
Pulmonary emphysema	26
Pulmonary fibrosis	9
Pulmonary edema	4
Pneumoconiosis	3
Pulmonary embolus	4
Asthma	16
Old tuberculosis	3
Bronchiectasis	4

GASTRO-INTESTINAL DISEASE	
Cholelithiasis	15
Duodenal Ulcer	18
Chronic pancreatitis	2
Diverticulitis	10
Small bowel obstruction	2
Achalasia	2
Hiatus hernia	6

MISCELLANEOUS DISEASES	
Diabetes mellitus	12
Cancer of rectum	6
Cancer of pancreas	3
Cancer of maxillary sinus	1
Leukemia	3
Arthritis, severe	14
Lues	6
Ruptured vertebral disc	6
Fracture of femur	7

ASSOCIATED UROLOGICAL DISEASE	
Chronic pyelonephritis	16
Hydronephrosis	10
Calculus disease	30
Bladder diverticula	21
Renal cyst	3
Cancer of bladder	4

Transurethral resection was done along with a second operation under the same anesthesia seventeen times; five times with rectal surgery and twelve times with inguinal herniorrhaphy. There were no complications as a result of combining these procedures.

Surgical Results

In this series, there were forty-one cases of carcinoma and 259 cases of benign hypertrophy. There were five instances of occult carcinoma, the malignancy not having been suspected pre-operatively or during operation. Complete removal of all adenomatous tissue was the goal in resection of the benign glands.

TISSUE REMOVED — BENIGN			
Grams		Patients	
10 to 20	—	58	52%
20 to 30	—	71	
30 to 40	—	33	
40 to 50	—	31	
50 to 60	—	17	48%
60 to 80	—	21	
80 to 100	—	5	
100 to 200	—	9	
Over 200	—	1	
(Average — 35.3 gm.)			

TISSUE REMOVED — CARCINOMA			
Grams		Patients	
Less than 10	—	1	
10 to 20	—	14	78%
20 to 30	—	17	
30 to 40	—	5	22%
40 to 50	—	4	
(Average 21.9 gms.)			

In this series of 300 only 24 patients received blood during the operation.

Deaths and Complications

There were four hospital deaths in this series, giving a mortality figure of 1.3%. The first was a 74 year old patient who had marked arteriosclerotic cardio-vascular disease, asthma and one previous myocardial infarct. He was evaluated pre-operatively as a fair risk. On the third post-operative day, at which time he was up and about, he had a second severe myocardial infarct and died. The second hospital death was that of a 55 year old patient who had chronic lymphatic leukemia in addition to widespread carcinoma of the prostate, grade IV with metastasis to vertebrae, ribs and lungs. He had an uneventful post-operative course until the seventh day when he developed a staphylococcus aureus septicemia. In spite of massive antibiotic therapy, he died on the 14th post-operative day. The third patient was a 79 year old who had arteriosclerotic cardiovascular disease and whose electrocardiogram showed myocardial ischemia. He was evaluated as a fair risk. On the third post-operative day he had a massive myocardial infarct and died immediately. The fourth was a 77 year old with uremia, the BUN improving pre-operatively from 68 to 51. He also had congestive heart failure on admission and had large varicose veins of both lower extremities. On the seventh post-operative day he had a massive pulmonary embolus and died immediately.

COMPLICATIONS

Extravasation	0
Intravascular hemolysis	0
Excessive bleeding	3
Inadequate resection	1
Difficulty in control	3
Epididymitis	7
Stricture (20 meatal)	27

Complications directly related to surgery are listed above. There were no cases of urinary extravasation or renal suppression due to hemolysis. Three patients had to be returned to the operating room for control of excessive bleeding. Two of these were on anti-coagulant therapy, one for thrombophlebitis following rectal surgery done during the same admission, the other for carotid artery insufficiency.

One patient who was advised to have open prostetectomy because of a very large gland insisted on transurethral resection. Fifty grams of tissue were removed at the first operation, after which he did well for one year. At this time, he developed bleeding and it was necessary to do a second procedure with an additional 48 grams of tissue removed. He has had no further difficulty. Although there was satisfactory function after the first procedure, this was included as an inadequate resection.

There were three patients with difficulty in control following operation severe enough to require urethral clamp. With sphincter exercise, two regained complete control after 6 months, the other after 1 year.

There were seven cases of acute epididymitis following resection. All had pre-existing lower urinary tract infection and all had bilateral vasectomy at the time of resection.

There were 27 cases of post-operative urethral strictures, 20 involving the meatus and 7 cases of stricture of the membranous urethra, all of which were satisfactorily corrected by office dilatation.

Pre-operative days in the hospital and total hospital days are figures that are usually related to complicating diseases rather than to prostatic surgery itself. For this reason, only post-operative days are considered.

POST-OPERATIVE HOSPITAL DAYS

Days:	4	5	6	7	8	9	10	over 10
Patients:	(40	120	72	30)	8	4	6	9

91 %

The average post-operative hospital stay in this series was 5.8 days with 91% of patients dismissed on the seventh post-operative day or sooner. The figures for average post-operative days are weighted somewhat by 9 patients who had over ten post-operative hospital days. These include all of the medical complications encountered in this series.

OVER 10 POST-OPERATIVE DAYS

11 days—Bilateral hernia repair
11 days—Old CVA hypotonic bladder
11 days—Post-operative bleeding
11 days—Congestive failure
14 days—Acute parotiditis
14 days—Acute myocardial infarct
20 days—Carcinoma with cord metastasis
21 days—Acute myocardial infarct
26 days—Pulmonary embolus and congestive failure.

Evaluation

The final evaluation of transurethral resection of the prostate must, of course, be made by the patient himself. His criteria for judging the operation will consist entirely of those subjective factors with which he is most vitally concerned. Namely, the safety of the operation, the degree of comfort which he enjoys during the post-operative period, the length of stay in the hospital, and most important, his functional end result. The increasing demand for this operation rather than for open prostatectomy does not derive from academic debate, but rather from the evaluation of ever increasing numbers of satisfied patients.

Trauma of the Chest From the Standpoint of the Internist*

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The role of the Internist in the management of patients with chest injuries is a definite and important one and often requires sound knowledge of pulmonary physiology for accurate treatment.

JUST what is the role of the Internist in the management of patients with injuries of the chest? At first blush one would feel we have little or no part to play in this important aspect of medical practice. On close study it is found we have a definite and important role to play.

Many fatal injuries are due to trauma involving intra-thoracic structures. Many of these occur in young individuals, resulting in loss of many working years. Several types of injury to the thorax are not immediately fatal and these often require sound knowledge of pulmonary physiology for accurate diagnosis and treatment.

Among battle casualties chest wounds cause 20% of the deaths on the battlefield. Approximately 8% of all battle casualties surviving long enough to be admitted to medical units are suffering from injuries to the chest. It might be of interest to some of you that the mortality resulting from chest wounds amounted to 60% during the American Civil War, dropped to 50% during World War I, and fell to 8.1% during World War II. This reduction in death rate came about as a result of better understanding of cardiopulmonary physiology, the use of antibiotics, blood transfusions, early vigorous resuscitation measures and timing of operative intervention. During the Korean War, deaths from thoracic injuries were reduced even further, due to rapid, atraumatic evacuation of casualties by helicopter and airplane to accessible surgical hospitals, and to refinements of care including antibiotics, transfusions and thoracotomy.

In all of this the Internist, especially the well-trained chest physician, can play an important part. Any physician may at some time have a need for knowledge concerning the management of thoracic trauma.

Objectives

In cases of thoracic trauma the objectives are the preservation and restoration of cardiorespiratory mechanisms, maintenance of oxygen supply and maintenance of an adequate circulating blood volume.

Resuscitation entails evaluation of the patient's general condition, treatment of shock, recognition and management of sucking wounds, maintenance of an open airway, recognition of hemothorax and pneumothorax, relief of pain in the chest wall, and, if possible during this period, administration of proper intravenous therapy and obtaining roentgenograms of the chest. Who is better qualified to supervise all this than the well trained chest physician?

In the management of thoracic injuries first treat shock and hemorrhage by judicious use of oxygen and transfusions so as not to upset the cardiorespiratory balance. Secondly, the thoracic viscera and the intrathoracic physiology and dynamics should be restored to their normal status by the quickest and most conservative methods possible.

Hemorrhage may come from the systemic or the pulmonary circulation. Bleeding from

*Presented at the KSMA Annual Meeting, September 20, 1961.

the intercostal or internal mammary vessels, a pulmonary artery or pulmonary vein may be responsible. All parts of the body should be examined for sources of hemorrhage with the patient completely undressed, because serious trauma to the chest frequently is associated with serious injury to other parts of the body.

Partial suffocation may be a prime factor in producing shock when the lungs are damaged. Removal of blood and mucous from the trachea and bronchi often is the most important factor in relieving shock. The possibility of partial suffocation should be considered before the patient's general condition is evaluated and before any major surgical intervention is attempted. Accumulated secretions may be removed by coughing in a patient not too severely injured, or by catheter suction of the trachea or by bronchoscopic aspiration if pain or severe injury prevents a satisfactory cough reflex. Tracheostomy should be done if there is not prompt clearing of the airways in a severely injured patient.

Character of the Injury

The character of the injury to the chest wall is important and the seriousness usually varies with the effect on the cardiorespiratory mechanisms. A small penetrating wound, with no wound of exit, or simple perforating wounds, with a small wound of entry and a slightly larger wound of exit, may require only a simple dressing, supportive measures and conservative management.

A slight injury, such as a fracture of a rib, in an elderly patient with reduced vital capacity may have a serious effect on his or her ability to breathe, whereas a large sucking wound of the chest may be tolerated for a long period of time by a healthy young person. If there is no visceral injury the serious effects of rib fractures will be in proportion to the splinting of the thorax and decrease in respiratory excursions resulting from pain.

The usual strapping of the chest with tape in such cases is not satisfactory because it produces little immobilization. Encircling the entire lower costal margin is efficient, but dangerous. It causes some restriction of the descent of the diaphragm and cannot be tolerated if the vital capacity is reduced significantly. Immobilization of the chest wall should be on a trial and error basis. An Ace bandage around the lower costal margin often serves very well. Drugs for relief from pain should be used with caution. Regional nerve blocks, at the fracture site or para-vertebral, are quite helpful and satisfactory in relieving pain. Each patient must be treated individually.

There are two very serious types of chest wall injury:

1. Those which produce open pneumothorax or a sucking wound.
2. The crushed chest, "flail chest," or "stove-in chest."

In the case of the chest injury with open pneumothorax, or a sucking wound, there is collapse of the lung on the involved side, shift of the mediastinal structures with compression of the opposite lung, resulting in reduced vital capacity, mediastinal flutter, reduced ventilation of the uninvolved lung, interference with filling of the right side of the heart and reduction in cardiac output. Here one may see the so-called pendulum respiration. The age of the patient, the original vital capacity and previous fixation of the mediastinum and pleura will help to determine the ability of the patient to tolerate the effects of a sucking wound of the chest.

Treatment

The immediate treatment is closure of the open wound with some type of pressure dressing (petrolatum gauze and heavy gauze dressing if possible), relief of pain by procaine nerve block or small doses of Demerol®, booster dose of tetanus toxoid, institution of antibiotic therapy, thoracentesis for removal of blood or air (or both), infusion of blood, plasma or Dextran for correction of shock, and transportation to a hospital as soon as possible. The patient should be transported with the injured side down, but may be allowed in the sitting position.

Pain may limit respiratory excursions, may prevent effectual cough, may result in retention of secretions and may lead to atelectasis and anoxia. Immobilization may relieve the pain, intercostal nerve block with procaine usually provides most satisfactory relief, but Demerol or morphine may have to be used with caution. Doses of these drugs should be small.

In the case of injury to the chest with multiple rib fractures and possible fractures of the sternum as in automobile accidents with

steering-wheel injury, there is loss of rigidity of the chest wall, the so-called "flail chest" or "stove-in chest." Here again we may see "pendulum breathing," with one lung breathing air from and into the opposite lung. There are paradoxical movements of the chest wall during breathing, with marked impairment of ventilatory function, and diminution of cough reflex. Fatal suffocation may occur rapidly. The physiologic effects are much the same as with a sucking wound of the chest. The initial management of such a case may mean the difference between life and death. There may be associated injuries such as hemothorax, pneumothorox, hemopericardium, head injuries, abdominal injuries and injuries of the extremities.

The application of some kind of rigid or semi-rigid dressing to the flexible chest wall will abolish paradoxical breathing, resulting in prompt improvement. The most important and effective measures in treatment of "flail chest" are a tracheostomy and the evaluation and correction of associated visceral injuries. With a tracheostomy it is possible to maintain a free airway by frequent aspirations, the dead air space is reduced and paradoxical motion is reduced. With tracheostomy and control of associated hemothorax and pneumothorax, external traction rarely is necessary. The use of fluctuating continuous positive pressure has been shown to be of value in the treatment of crush injuries.

Hemothorax

Hemothorax is a frequent complication of severe thoracic trauma, as in automobile accidents and war injuries. Hemothorax is the most common complication of both penetrating and non-penetrating wounds of the chest. The bleeding often is slow and continuous over a period of many hours. Intrapleural blood usually clots slowly and incompletely. Sometimes it is defibrinated by cardiac and respiratory movements, fibrin being deposited on the pleura. If a solid clot forms rapidly it makes diagnosis and treatment difficult. Injuries causing hemothorax may have damaged other structures such as the diaphragm, liver, stomach, spleen and intestines. Here there is great danger of bacterial contamination. Hemothorax causes an outpouring of fluid and inflammatory elements resulting in sustained pyrexia. Infection causes a spiking, septic type of fever.

Immediate treatment consists of aspiration of the blood from the chest, care of the wound, treatment of shock, use of blood transfusions when indicated, control of intrapleural tension and use of oxygen therapy. The patient should be placed with his injured side down and with the open wound, if present, in a dependent position. If blood reaccumulates, enough should be removed to bring the mediastinal structures back to normal position. Injection of penicillin into the pleural space may help to prevent infection. Clotted hemothorax can be treated successfully at times by intrapleural use of fibrinolytic enzymes. If bleeding tends to persist and hemothorax continues to increase in spite of two or more aspirations, thoracotomy should be done to locate and control the source of the bleeding.

If Pneumothorax Occurs

When pneumothorax occurs as a result of trauma it usually is accompanied by hemothorax. A valve-like mechanism may develop, resulting in tension pneumothorax with displacement of the mediastinal structures to the opposite side, impairment of the function of the opposite lung and circulatory difficulties that may be serious. Subcutaneous emphysema may accompany pneumothorax.

Treatment consists of aspiration of as much air and blood as possible, repeating this until the lung is re-expanded. A patient with pneumothorax may be transported safely with a needle in the second intercostal space in the midclavicular line with a flutter valve attached. If, after aspiration, pleural pressures remain positive or unchanged a major wound of the lung may be suspected. This calls for treatment by insertion of an intercostal tube with connection to an under-water seal.

If there is continued massive leakage of air after the insertion of an intercostal tube, atelectasis of the lung or a lobe after decompression, especially with minimal or no evidence of hemothorax or rib fracture on roentgenological examination, damage to a major bronchus is suggested. This calls for surgical treatment.

Tamponade and Other Damage

Hemopericardium and cardiac tamponade may result from injury to the surface of the heart. The accumulation of blood in the

relatively nonelastic pericardium will compress the chambers of the heart and may cause death. There will be increasing venous pressure with distention of the neck veins, the cardiac size will increase, the heart sounds become faint or inaudible, the blood pressure drops and the pulse pressure becomes small. There may be no visible pulsations of the heart on fluoroscopy.

Aspiration of Blood

Treatment consists of aspiration of blood from the pericardium with a large needle and syringe. This should be done no more than twice. If hemorrhage into the pericardium continues, thoracotomy and control of the source of bleeding will be necessary.

In blast injuries traumatic pneumonitis may occur. The lung is totally or partially consolidated and the alveolar spaces are filled with blood and superimposed inflammation. The physical signs are those of pneumonia. The x-ray findings may be suggestive of hemothorax. Dyspnea is the outstanding symptom. There may be chest pain, cough and expectoration of blood-stained sputum. These patients usually recover in a few days if there is no other injury. Treatment should consist of symptomatic measures plus the administration of antibiotics.

In some injuries of the chest there may occur the so-called traumatic "wet lung," characterized by excessive accumulations of secretions and blood in the tracheobronchial tree, inadequate removal of the fluid, bronchospasm, obstruction of the airways by exudate, mucous and blood, depression of the cough reflex from over-sedation or unconsciousness. The symptoms may be shock, hemoptysis, chest pain, restlessness, wet, painful cough, cyanosis, dyspnea and orthopnea. There may be dullness and diminished breath sounds on physical examination.

Abolish Chest Pain

Treatment should consist of the abolition of chest pain, preferably by nerve block, clearing of the tracheobronchial tree, oxygen therapy and the administration of intravenous fluids.

Injuries to the esophagus are unusual except as a result of endoscopic examination. If suspected a swallow of iodized oil should be given and x-ray evidence of a leak should be sought. Antibiotic therapy may help control the mediastinitis and pleuritis but operative repair of the esophagus may be necessary.

Injured Diaphragm

The diaphragm may be injured by penetrating or crushing injuries of the thorax or the abdomen. In a penetrating wound by a missile this must always be suspected and looked for. Such an injury will call for a change in the plan of treatment. Injuries through the left leaf of the diaphragm are more serious than those through the right. Mortality is associated chiefly with the abdominal component in such injuries.

Late effects may develop in a patient who seems to have made a recovery. Aneurysms, especially false aneurysms, pericardial adhesions, arteriovenous communications, late hemorrhage from infection or retained foreign bodies, residual sepsis such as bronchiectasis, chronic empyema, bronchopleural fistula and chronic lung abscess in association with a foreign body. It is the business of the Internist to know all about these possibilities, and to be on the lookout for them. He may be of great assistance to a patient, his family physician, or a surgeon through having such knowledge and applying it properly. He should have some knowledge of when thoracotomy may be indicated, although most chest injuries respond well to conservative treatment.

Thoracotomy Indicated

Thoracotomy may be indicated for the control of persistent intrapleural hemorrhage, for debridement and closure of sucking wounds, exploration of thoraco-abdominal wounds, wounds of the trachea, bronchi and esophagus, cardiac tamponade and myocardial lacerations, and vascular injuries, especially false aneurysm.

Summary

Proper management of chest injuries requires a thorough knowledge of cardiopulmonary physiology.

In the early stages resuscitative and supportive measures are necessary. Any physician may be called upon at times to manage such a problem.

Certain established principles of management, if adhered to, will result in the saving of numerous individuals suffering from chest injuries.

Fractures of the Femoral Neck Due To Irradiation*

K. Armand Fischer, M. D.
Louisville, Ky.

Irradiation fractures of the femoral neck are frequently recognized late and treatment at this stage does not allow a good result. Early diagnosis and treatment insures a good result.

IRRADIATION fractures of the neck of the femur have been amply described by numerous writers in the past ten years. At one time, an unfavorable prognosis was given to this condition, but in recent years the reports of these fractures have been giving a more favorable outcome. It is now apparent that with early recognition of this type of femoral neck fracture, the prognosis is unusually good.

There are reports of healing of these fractures without any specific treatment other than protection from weight bearing. However, one would hardly justify this as a routine procedure, because they may go on to complete failure. Treatments suggested have run the gamut of nails or pins, bone grafting, spica casts, osteotomies, fusions, excision of the femoral head, reconstructive procedures, and replacement prostheses. With this many operations being recommended, it is apparent that these fractures are seen in many stages; some early, some late, so that many forms of therapy have been used.

The pathology of this condition has been amply studied, in femoral heads which have been removed and in core biopsies taken at the time of surgery. Pathological sections reveal areas of osteoporosis in the femoral neck. Osteoclastic activity in this osteoporotic bone is absent, but osteoblastic activity is present always in some degree.

Usually, a "stress" type of subcapital, or neck, fracture occurs through osteoporotic bone.

Other secondary findings are those of general injury and repair changes or new bone found around old, partially necrotic, or atrophic trabeculae. There is occasional thickening of the vessel walls and mild fibrosis. In some patients, segmental acetabular fracture has been found secondary to osteoporosis. In these cases, any additional trauma has resulted in necrosis of this area and fragmentation of the femoral neck. At times, a partial necrosis of the subchondral cortex and trabeculae away from the fracture site is thought to be due to irradiation damage to osteocytes directly, or, to a lesser degree, as a result of irradiation injury to the blood supply. Usually there is a good blood supply and vascular damage from irradiation is insufficient to impair the healing and repair response in these fractures. It is thought that the absorptive and osteoporotic changes probably are on a vascular basis.

Diagnosis and Treatment

To improve the treatment results in this type of fracture of the femoral neck the possibility of this complication must be kept in mind in all patients who complain of knee or hip pain following pelvic cancer irradiation. Often, early x-ray films made when such a patient has pain may fail to show the lesion, but a series of films several weeks apart will show an area of osteoporosis, and then with minor stress and

*Presented during the meeting of the Kentucky Orthopaedic Society, KSMA Annual Meeting, September 19, 1961. From the Section of Orthopaedic Surgery, Department of Surgery, University of Louisville School of Medicine.

strain, a fracture line appears which gradually separates with increased stress and strain. If the extremity is not protected during this time, most cases will show displacement of the fracture and will require replacement of the head, as well as operative fixation of the fracture.

One must always keep in mind the possibility of pathological fracture through tumor metastasis. Usually these do not heal whereas those due to irradiation can be anticipated to heal in time, even when sometimes the fracture is recognized late and a varus position has occurred. In the case of patients who use crutch walking only, with the varus position, there usually results some disability in the hip, with loss of motion and a flexion contracture. Usually irradiation fractures occur in women who have received treatment for uterine carcinoma and ovarian carcinoma, but a male may be subject to the same type of lesion when roentgen therapy is used for carcinoma of the genitalia.

Average Age is 63 Years

In reported cases, the age incidence has been from 37 years to the aged. The average age of the patient is 63 years. The time of occurrence of fracture following therapy ranges from 4½ months up to as long as twelve years, with the majority of cases occurring within five years following therapy.

The onset of pain may be acute or insidious. If the fracture is not recognized early, then the deformity increases, with limp, pain on weight bearing, and a gradual fixed external rotation of the hip. Shortening of ½ to 2 inches may occur if the fracture comes completely apart, and then there are symptoms like any other acute fracture of the hip. Cases of bilateral post-irradiation fractures have been reported. We had one in our group, the fractures occurring approximately a year apart.

As stated before, there are many forms of treatment for irradiation fractures. When one encounters a fracture that has been present for a number of weeks, and there is a varus deformity with no pain, one must consider simple crutch walking and allowing the fracture to heal over a number of months. One must take into consideration the age of the patient and the possible presence of malignant disease elsewhere. If the fracture is completely displaced, a radical type of treatment is indicated, especially if there is extensive primary malignant disease elsewhere, and one desires to ambulate the patient as quickly as possible. One would hesitate to use extensive reconstructive procedures if the prognosis was bad for longevity.

Summary

1. One must keep in mind a characteristic clinical picture, in which there may be premonitory pain without x-ray evidences of disease.

2. The onset may be acute, with deformity and displacement of the fractured neck of the femur.

3. One must think of the likelihood of irradiation fractures in males and females, and generally this takes precedence over the possibility of metastatic invasion.

4. The damage from irradiation of bone is thought to be based on loss of osteoclastic activity, death of bone cells, and some minor avascularity, which all result in osteoporosis. Then, stress and strain in the presence of these factors produces a stress fracture.

5. No one specific treatment is applicable to all these fractures.

6. The prognosis is generally favorable, but the disability varies.

Louisville General Hospital

Visceral Larva Migrans*

THIS is the case of a Negro male admitted to Louisville General Hospital as a toddler and followed at frequent intervals over a period of four and one-half years because of a most interesting illness.

After an apparently normal delivery, the infant did fairly well during the first one and one-half years of life except for frequent upper respiratory infections and the occurrence of pertussis at seven months of age. At the age of 21 months (See Figure 1) he had a rather severe undifferentiated upper respiratory infection. At this time, the abdomen was noted to be somewhat protuberant but the liver and spleen were not enlarged to palpation. A roentgenogram of the chest was normal and the white blood cell count was 52,000/mm³., of which 66% were mature eosinophils. Clinical recovery was uneventful. During the ensuing nine months the parents became aware of gradual enlargement of the abdomen.

Abdominal Pain

At 30 months of age the child complained of abdominal pain coincident with bilateral swelling of the ankles. Examination at the time of hospitalization revealed a 29-pound colored male in no acute distress, afebrile, with a profuse mucoid nasal discharge. The abdomen was moderately distended and the liver edge extended 5 cm. below the right costal margin and the spleen was enlarged to 4 cm. below the left costal margin. The surface of both organs was smooth. Non-pitting edema of the ankles was of a mild degree. Blood pressure, pulse and temperature were normal. A roentgenogram of the chest demonstrated a pulmonic infiltrate in the right middle lobe. Study of the peripheral blood revealed the hemoglobin to be 10.4 gm.%; white blood cell count of 55,000/mm³. with 70% eosinophils; 17% segmented neutrophils; 9% lymphocytes and 2% monocytes. There were no eosinophils in the nasal mucus and no ova or parasites in stool specimens. Urinalysis, sickle cell preparation, serum electrophoresis and paranasal sinus roentgenograms were normal.

Diagnosis Made

With a history of close contact with dogs and dirt-eating, plus the clinical findings in a toddler of hepatosplenomegaly, leukocytosis with marked eosinophilia and a pulmonary infiltrate, the diagnosis of visceral larva migrans was made and the patient was started on meticorten 30 mg. daily and tetracycline 375 mg. per day. After one week of therapy, complete resolution of the pulmonic infiltrate had occurred and decrease in the size of liver and spleen was obvious. Meticorten was continued in decreasing dosage for three months and then discontinued. At this time, the chest roentgenogram was normal, liver edge extended 2½ cm. and spleen ½ cm. below the costal margins and the total white blood cell count was 25,300/mm³. with 23% eosinophils.

Two weeks after meticorten was discontinued a papular rash appeared over the most of the body. This rash was not associated with fever and persisted in varying degree for about three months.

On June 4, 1959, at 40 months of age and six months after steroids had been discontinued, the patient was again admitted with symptoms and signs identical to those on the previous ad-

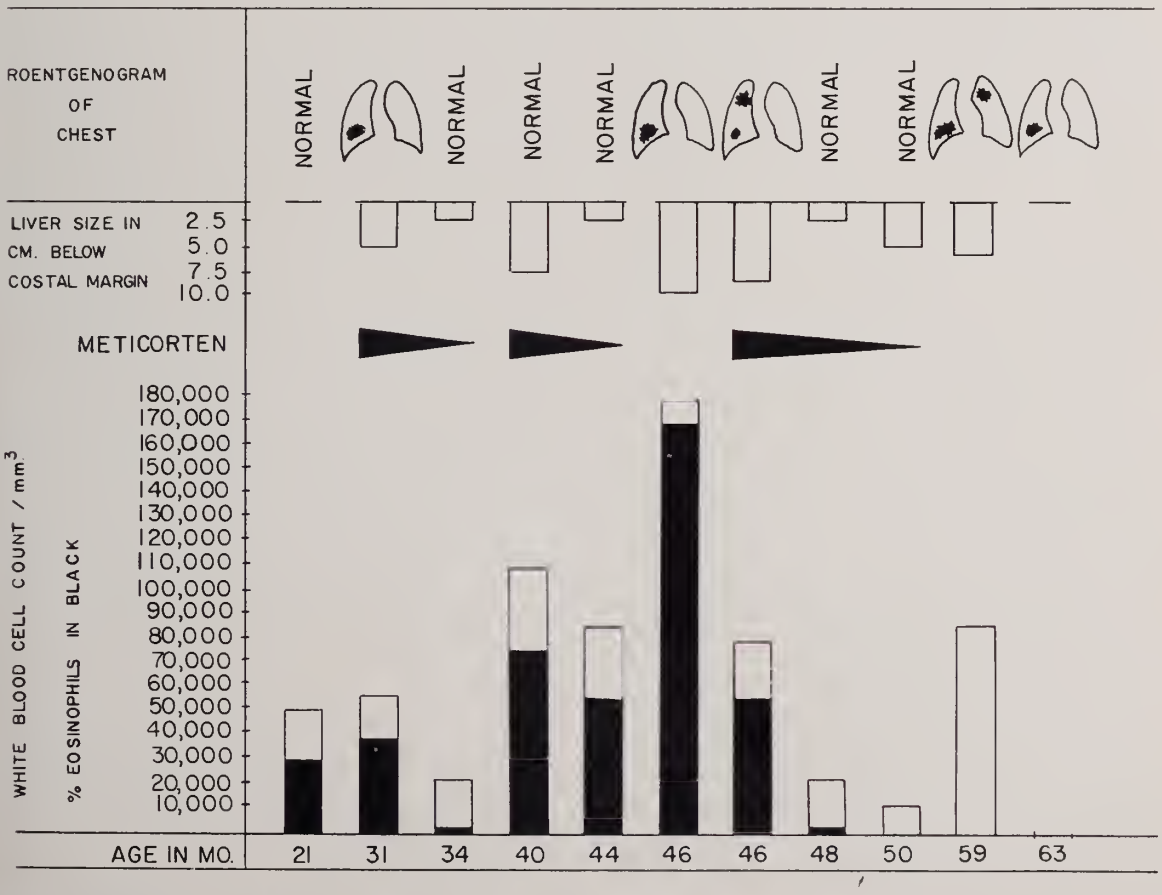
Case report, Louisville General Hospital, Department of Pediatrics.

mission except for the absence of pulmonary lesions. Meticorten was again administered and after one week, the liver edge regressed from 8 to 4 cm. and the spleen from 8 to 2 cm. below the respective costal margins and the white blood cell count decreased from 108,000/mm³. with 84% eosinophils to 43,000/mm³. with no eosinophils. Steroid therapy was maintained for four months.

The patient's four siblings — ages eight years, seven years, six years and one year, respectively — were examined and found to be normal in all respects except for a 16% eosinophilia in the six-year-old sister. Stool examinations for ova and parasites were negative from all the children.

On December 28, 1959, at 46 months of age, the child was readmitted with fever, abdominal pain, pedal edema, hepatosplenomegaly, pneumonic infiltrate and a leukocytosis of 176,000/mm³. with 94% eosinophils. Hemoglobin, serum bilirubin and BSP excretion values were within normal limits. The bone marrow cytology was normal except for the predominance of eosinophilic myelocytes with normal maturation. Blood and bone marrow cultures produced no growth of bacteria or fungi. Total serum protein was 9.3 grams % with 4.4 grams % albumin and 4.9 grams % as globulin. A third course of meticorten and antibiotic therapy was started. After four days of treatment, the initial pulmonary infiltrate in the right lower lobe had resolved but almost complete consolidation of the right upper lobe had occurred. At the end of two weeks of therapy, the chest roentgenogram was normal. Meticorten was continued for the ensuing five months.

Three weeks after steroid therapy was discontinued a generalized papular rash appeared on the upper and lower extremities. The rash was pruritic and the papules had central pale areas. No further steroid therapy was given. In October 1960 he had bilateral pulmonic infiltrates. In January 1961, at 59 months of age, the child was hospitalized with coryza, cough, wheezing and pneumonic infiltrates in the right lower lobe and the left upper lobe. The white blood cell count was 87,000/mm³. wth no eosinophils by differential count. Pulmonary symptoms persisted through March 1961 when only an infiltrate in the right hilar



region was present. At this time the liver and spleen were not enlarged.

The child was seen on November 16, 1961 at 69 months of age, with only the symptom of cough. The liver and spleen were not enlarged and the chest examination was normal.

Comment: Walter T. Hughes, M.D.
Assistant Professor of Pediatrics
School of Medicine
University of Louisville

This patient demonstrated at one time or another almost all the known clinical manifestations of visceral larva migrans, namely: symptoms of abdominal pain, pedal edema, cough and wheezing, physical signs of hepatomegaly, splenomegaly, rhinitis, generalized papular rash, pulmonary infiltrate and asthma, and hematologic findings of marked leukocytosis with eosinophilia and hyperglobulinemia. The age of the patient and the history of dirt-eating and contact with dogs are typical for the disease. There was no evidence of central nervous system involvement or endophthalmitis in the case presented, however, these findings have been reported in a few individuals.

Although the dog has been "man's best friend" and the traditional boyhood pet for centuries, it was only 10 years ago that Beaver and his associates brought attention to the role of this animal in a new disease of infants and small children. They proposed the entity of visceral larva migrans and related it to the migration of Toxocara larvae into the viscera of the human. Although the dog ascarid, Toxocara canis, is the more frequent source of human infection, the cat ascarid may on occasion produce the same disease.

Fecal examination on 1,465 dogs by Ehrenford[2] showed an overall incidence of 21% infestation with Toxocara canis, a value in agreement with data from other authors. Puppies are more frequently infested than adult dogs.

In the human infant or young child larvae hatching from ingested embryonated Toxocara eggs can penetrate the mucosa of the small intestine and reach the liver, lungs or other organs, but remain larvae without completing the cycle. Migration of the larva through the viscera produces a granulomatous lesion with eosinophils and fibrinoid connective tissue surrounded by epitheloid cells. An underlying tendency of hypersensitivity may play a part in the syndrome. The disease appears to be limited almost exclusively to children in the toddler and pre-school age groups.

Since the larvae do not return to the intestine to develop into the adult worm, examination of the stool is of no help in establishing the diagnosis. The organism can only be demonstrated by biopsy of the involved organ. However, the findings of hepatomegaly, eosinophilia and hyperglobulinemia in a pale toddler who has eaten dirt contaminated by a puppy warrant the diagnosis of visceral larva migrans.

With the typical syndrome, as in the case presented here, biopsy is not necessary to establish the diagnosis. However, the disease may exist in varying degrees of severity and in the less typical cases biopsy of the liver may reveal the nematode larva or the typical lesion produced by the parasite. Skin tests are not entirely reliable and serologic aids are limited by strong cross reactions with Ascaris lumbricoides.

Prevention Is Important

Therapy is purely symptomatic. Prevention by protecting small children from contact with infested dogs and cats is important. These pets should be dewormed at frequent intervals and contaminated topsoil may be turned under to put the nematode ova out of reach. Continued exposure to the ova may prolong the course of the disease as may have occurred in the above case.

Attempts at specific therapy with arsenicals, Hetrazan, Piperizine citrate and Delvex have been unsuccessful. Although the use of a cortisone derivative in the patient presented appeared to temporarily affect the pulmonic infiltrate, liver and spleen sizes and the white blood cell count, this probably did not affect the total course of the illness sufficiently to justify its subsequent use in this disease unless, perhaps, toxicity is severe. The use of steroids in other reported cases has proven disappointing.

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Serving As KSMA President Is Rewarding

Richard G. Elliott, M.D.*

I DEEPLY appreciate the honor which has been mine to be your president for the past year. It is an experience that I wish each of you could enjoy. It is a time-consuming and responsible position, but the rewards in seeing and understanding KSMA in action and of the personal contacts and friendships with our members make this of small account. In the past I have listened to a number of presidents' addresses which were in tone and content valedictory speeches. I should like to make it clear now that this is not an address of farewell — I hope to be around for quite a while longer and to be active as long as KSMA or the Fayette County Society will give me the opportunity.

Review of Developments

In the few minutes given to me I should like to mention some of the developments of the past year which I feel will be of lasting significance to the Association. I wish that I could summarize all the work which has been done during 1961. It would amaze you.

The House of Delegates meets at the time of the Annual Meeting and at the time of the Interim Meeting in the spring. The Board of Trustees meets at least four times during the year to consider matters which must be settled between the meetings of the House of Delegates or may be referred to it for action. The Executive Committee meets to prepare for the meetings of the Board of Trustees and to consider emergencies which may arise.

There are more than 50 committees which investigate, consider and recommend action to the Association on matters reflecting every phase of the practice of medicine in the State. Exclusive of the House of Delegates during the past year there were 62 meetings involving 2,300 man-hours of attendance and the members traveled 74,000 miles to be there. That shows that we have a dynamic and active group which is interested in the problems of organized medicine in Kentucky. On at least four occasions delegations of our members traveled to Washington to present our views to our lawmakers there.

While all this work is going on our Headquarters Office force is arranging for the Annual and Interim Meetings; the many committee meetings; our displays at the Kentucky Education Association and the State Fair; issuing the Secretary's Letter and the News Caps, and seeing that The Journal of the KSMA reaches your desk each month. Their tasks are endless and they do them well.

Many Significant Activities

Out of the many activities of the Association during the past year there are several which I feel will be of lasting significance. Most of them were conceived before I became president but they have come of age and taken their places in our over-all program this year.

Our Association is growing. We now have more than 2,200 members. During the past year our gain in membership in the AMA entitled us to a third delegate. With the increase in membership and the increase in our activities we found that we were outgrowing our headquarters office. A Building Committee, made up of Hoyt D. Gardner, M.D., Louisville; Nathaniel L. Bosworth, M.D., Lexington, and George F. Brockman, M.D., Greenville, was appointed to recommend to the House of Delegates in 1960 the practicality of building a Headquarters office building.

The late Doctor Elliott, Lexington, was immediate past president of the Kentucky State Medical Association, and this article constitutes The President's Address at the recent annual meeting. He passed away as the Journal was going to press and an appropriate write-up on his death will appear in the April Journal.

This committee not only met 13 times but they toured our neighboring states and inspected the headquarters buildings of their medical societies. The committee report was a model of clarity and completeness and the House of Delegates authorized them to purchase land and to proceed with the construction of a modern office building.

This was done and on Sunday, May 21, groundbreaking ceremonies were held with Lieutenant Governor Wilson W. Wyatt as the principal speaker. The building is located at the corner of Janet and Abigail Avenues, facing the Watterson Expressway near the Taylorsville Road turnoff. (The Headquarters staff moved into the building January 26.)

Building Has Ample Space

The building is a modern one-story plan with ample space for the Headquarters activities and ample parking space. Future growth was also considered and there is land available for expanding the building. This has been done without raising the dues of our members or levying any special assessments. This building is one of which the Association may be proud. It is a symbol of the permanence of our Association, reaching back into our rich historical tradition, but extending into the future with unlimited possibilities for growth to meet the needs of a growing medical profession.

During the past few years the AMA has become increasingly alarmed at the mounting number of deaths and injuries on our highways. Following their lead, KSMA this year appointed a Highway Safety Committee. Feeling that we should make a start with our own members, the Committee has chosen to emphasize the place of the safety belt in accident reduction. They hope that through a campaign of education they can have all our members install seat belts in their cars and use them routinely as they make their rounds. They hope that the physicians will in turn educate their families and patients in their use so that many cars on the roads of Kentucky will be so equipped as a result of our efforts and that with increased use there will be a noticeable reduction in deaths and serious injuries on our highways.

This is one example of the many ways in which we are helping to solve problems which affect the life and welfare of the people of our State alone or in conjunction with other interested groups. I am sure this committee would welcome suggestions from any of our members as to how they may more effectively carry out their program or other projects which they might undertake.

School Health Activities

For a number of years we have had a School Health Committee which has cooperated with education officials on preschool examinations and better health care of our school children. Each August there is a coaches' clinic for high school coaches held at the University of Kentucky. For the past three years this committee has sponsored an athletic injury prevention conference as part of this program. These have been well received by the coaches and the AMA has requested that Kentucky conduct a pilot study, holding clinics in several parts of the State so that more coaches may be reached.

The Committee plans to do this and it will also supply speakers to any county medical society which wishes to have a program on this subject.

As an outgrowth of this interest in our young athletes and because little league baseball, peewee football, as well as high school events are increasing each year I hope that many of you will volunteer to be team physicians to replace the barbers, chiropractors and so-called trainers that too often make the vital diagnosis and prescribe treatment for these children. This is our responsibility. Let us shoulder it.

Another field in which we have progressed this year is that of politics. As the Federal Government grows larger we are more often called upon to defend our right as free citizens to practice medicine to the best of our abilities without direction and regulation from either physicians or civilians in the bureaucracies of Washington.

Medical Care of Aged

This year the care of the aged, financed through Social Security, did not come before the Congress. Next year the Administration is expected to present it and to attempt to hammer it through with all the means at its disposal.

During the past year it was my privilege to go to Washington, D.C., and meet Secretary of Health, Education and Welfare Abraham A. Ribicoff. If he is an example of the men who will frame the destinies of the physicians of our country — of you and me — it is imperative

that we exert ourselves to the uttermost to resist these proposed laws and to use every means within our power to see that these bills are not passed.

During the next year, as you have in this past year, you will be kept informed of political developments which will affect you and which you must support or oppose. If each member of this Association would respond wholeheartedly to the requests of your KSMA National and State Legislative Council we would be a force to be reckoned with; a power as yet unfelt.

When the State Legislature meets (now in session in Frankfort), the KSMA will be supporting a number of bills relating to health and medicine. Among them is a bill for the compulsory vaccination of children against pertussis (whooping cough), diphtheria, poliomyelitis and, possibly, tetanus. This is good and needed legislation. We should each talk to our local legislators and see that it and the other bills which we support are enacted into law.

These are four facets of our work which have impressed me during the past year. There are many more equally important. I wish that I might call each man by name who has contributed to our work. It is their devotion which makes us the effective Association whch we are and as long as our members continue to give of themselves and their time our future is assured.

I know that next year will be a good one and I am looking for great things from the Association under the leadership of Gaithel L. Simpson, M.D., Greenville.

For the Record

Americans are a prudent people. Look at the evidence: In a recent poll, 63 per cent of those questioned said the President and Congress should do something about holding down prices and preventing inflation.

Americans are a good-hearted people. Look at the evidence: In the same poll, 52 per cent of those who answered said they thought the powers that be ought to get busy and provide more medical care for the aged.

Americans are a generous people who like to see the other fellow get a break. Look at the evidence: In the poll, 48 per cent said Congress and the Chief Executive should boost the minimum wage to $1.25 per hour.

Americans are people who also like to see themselves get a break. Look at the evidence: The poll turned up 46 per cent who thought the government ought to "reduce taxes for people like myself."

A higher minimum-wage—but no price rise and no inflation. More medical care for the aged, more federal aid to education (said 40 per cent), more housing and slum clearance (38 per cent), more spending on national defense (31 per cent) and to cut unemployment (28 per cent)—but still "balance the budget by cutting government spending" (37 per cent) and, above all, "reduce taxes for people like myself."

Yep, Americans are prudent, good-hearted, and generous. But Americans, judging by that poll, also are a people who need a fast lesson or two in arithmetic and the relationship between cause and effect.

—*Star-Journal,* Warrensburg, Mo.

Reprinted in the Texas State Journal of Medicine, November 1961



We Are Not So Sorry As Advertised

THERE appeared in the February 3, 1962, issue of the Saturday Evening Post an editorial entitled "The Doctors and the AMA." With the backdrop of a few honeyed words of faint praise for physicians in particular and the medical profession in general, the editor undertook to severely criticize the AMA for its policies and practices. This is not unusual. Sniping at the AMA is a considerably shop-worn exercise for a good many editors and columnists when they seem to run out of anything more stimulating or constructive to write about. This would not seem so undesirable or unsportsman-like if in their vitriolic attacks they adhered to the truth or reasonable facsimile thereof.

An Unwarranted Assertion

To say that doctors as a group have been against almost everything that America is for is a very broad and unwarranted assertion. Fifty years ago the AMA urged the creation of a department of health in the President's cabinet which has now become known as the Department of Health, Education and Welfare. It sponsored the establishment of the United States Public Health Service, the Federal Food and Drug Administration and public health departments in the several states. The entire 115-year history of the American Medical Association is a record of medical progress embracing all of the present activities of public health, improvement in the standards of medical education and ethics, postgraduate training of physicians for general practice and rigid standards of specialized training for those who would devote their work to a selected field.

The editor states that the AMA opposed hospital insurance despite the rapid growth of this enterprise in which some 130,000,000 Americans have now participated. Doctor Larson in his letter of reply has stated that since 1917 the AMA is on record as encouraging and assisting in the development of volunteer health insurance. Few of us now active in medical affairs were sufficiently interested or informed to verify that record personally, but we do know that establishment of Blue Cross in 1938 and Blue Shield in 1948 in Kentucky were effected by members of our state society and that our association provided the first $25,000 to launch this program. And we know that we as individual physicians, in pledging our support, agreed to accept whatever portion of fees the program would be able to meet if and when it ran into financial difficulty. This has been true in most of the 70 odd Blue Cross-Blue Shield plans that have been established in the United States. They have been initiated, sponsored and controlled by physicians with the approval of the AMA, and we have supported with almost equal energy the many forms of private prepayment insurance that have been offered to the public.

Around-the-Clock Service

He states that the kindly family doctor does not give us the around-the-clock service he once did. The fact is that the same proportion of babies are born in the hours between dark and daylight now as in the good old days and a doctor is there to attend the mother in her labor in a vastly larger percentage of cases than a generation or more ago when this practice was largely in the hands of midwives or even less adequately trained individuals. The same proportion of emergency operations and treatments of accidental injuries are attended around-the-clock now as ever before and the same proportion of medical emergencies arise demanding the physicians care. We invite this editor to spend one 24-hour period in any of our hospitals and learn for himself how much around-the-clock service is being administered

by physicians while nonmedical people sleep or recreate and we would invite him to spend a 24-hour period with any general practitioner, internist or surgeon if he would care to verify his careless remark.

This writer deplores the physicians' "pompous attitude" in relation to patients. That is a description which most of us would scarcely recognize because we seldom confront it. He also deplores the doctors' expression of opinion in political and social arenas. Now for years there has been a great hue and cry for physicians to participate more actively in the political and social affairs of their communities and we have been most severely criticized because we confine ourselves to our own profession to the neglect of these civic activities. Why should not a physician have an opinion and express it on political and social matters? Is he not among the best educated of the members of any of our professions? Does he not have daily contact with multitudes of citizens in every walk of life and learn of their problems and their aspirations and their preferences? Is his information not broadened and deepened by travel and social contact beyond the opportunities of most citizens and would these factors not permit him to have a better and more constructive opinion in political and social affairs than most of his contemporaries?

More Suits Against Doctors

The editor states that the vast increase in the number of suits against doctors and the sharp decrease in the number and caliber of applicants for medical education indicate that the medical profession is in serious trouble with its public relations. There are more lawsuits against doctors, but there are also more lawsuits for industrial injuries, traffic injuries, libel action, divorce and every other part of legal practice. The number of physicians (approximately 130) per 100,000 population, according to the United States Department of Commerce, has not changed significantly from 1921 to the present day. In 1922 there were about 2500 graduates in medicine. In 1950 there were 5,500. In 1961 there were 6,860. It has required this increasing number of graduates in order to maintain our proportion of physicians to population, which, incidentally, is the highest of any nation in the world.

A study conducted by the AMA in 1961 revealed that the scholastic standing of entering medical classes has remained essentially the same from 1952 to 1962. It is true that we for the first time are embarked on an activity of encouraging more men of higher scholarship to enter our medical schools but this is equally true in the quest for candidates for engineering, the ministry and the teaching profession. The financial rewards in industry have, in fact, offered a much stronger competition than ever before for the young man who would otherwise enter a profession.

Socialized Medicine

This gentleman states that so far as he knows there is no serious support anywhere in America for anything resembling socialized medicine. We wonder where he was in the 1930's when the first strong pressure for government control of medicine was exerted. Where could he have been in 1948 and '49 when the Wagner-Murray-Dingell legislation was so dangerously near enactment? We only hope that he is right in his assertion and that the present struggle in which we are engaged will not be won by those who desire further extension of government control in medicine and if complete government control of medical practice is not socialized medicine, the definition of these terms is not understandable.

This author suggests that the most effective way of defeating the presently urged plan of the Administration would be that physicians pledge to withhold their cooperation should it be enacted. We would counter with the proposal that the safest solution of this dilemma is in its defeat in Congress. Whatever the AMA or the medical profession may or may not be, it is not a union and will probably never resort to the tactics of strike. That would be at the expense of the health of our American people of which we are proud to call ourselves the chief custodians.

Asks Responsible Statesmanship

The editor finally calls upon the members of the AMA for responsible statesmanship. He challenges us to devise a workable plan that will be more effective than Social Security supported and government administered care for the aging segment of the American population. The AMA, Blue Cross-Blue Shield and private insurance companies have accepted that challenge and for more than two years have been in the process of evolving a better program. We think that the lack of statesmanship and

professional guidance in the field of health is not so great as this editor would have us believe. The American Medical Association is not perfect. It cannot be always right—but it is the most active, most powerful and most effective agency for better health in the world today.

Sam A. Overstreet, M.D.

Social Security For Physicians

Our elected representatives, in the exercise of such wisdom as they have attained, are proposing Social Security coverage for self-employed physicians. As this is new to us, I have attempted to prepare a summary of the principal provisions.

The Social Security Act can no more be summarized accurately and briefly than can the Book of Proverbs. This discussion presents the situation of a fully insured contributor at $4,-800 per year. In it, monetary sums are usually accurate in the absolute sense although in a few instances deviations of 0.30 are possible. Categorizing statements (eligibility, dependent, etc.) are probably accurate to within ± 5 per cent. "Earned income" expresses the usual concept of wage or salary payments, or analogs. It excludes income from rent, dividends or interest payments.

Survivor Benefits

A widow receives $95.30 a month while there is a surviving child younger than 18 years. A widow who remarries loses this benefit, but the child continues to receive benefits of $95.30 per month. After the youngest child has attained age 18, the widow is without benefits until she is 62, at which time, if not married, she would receive benefits of $95.30 a months for life. Either a child under 18 or a widow, otherwise eligible for benefits, loses the benefit of they obtain earned income of over $100 a month. The maximum family benefit is $254 per month.

Retirement Benefits

A contributor who retires at 65 receives benefits of $127 a month for life. His wife, if over 65, receives an additional benefit of $63.50. On the death of the taxpayer, the widow's benefit would be $95.30, but would terminate if she remarried. If the wife is between 62 and 65 when the insured retired, she could elect a smaller benefit at the younger age, but this would not increase when she attained age 65. The choice of earlier, but reduced payments, would not affect her right to $95.30 a month as a widow. (If this is confusing, try the original). Again, earned income of $100 a month voids benefits.

Disability Benefits

Total and permanent disability at age 50 or over provides benefits of $127, after a waiting period of six months. When the disabled attains age 65, the retirement schedule (above) would apply. Disability prior to age 50 entitles the taxpayer to "freeze" income, to insure payments at the highest attained rate, when eligibility for payments is established at age 50. Again, for the rehabilitated disabled, subject to certain qualifications, attainment of earned income of $100 per month voids benefits.

The Cost

As determined by Congress, self-employed persons with an earned income of over $400 make percentage contributions on all income to $4,800 per year.

The table below on the left indicates these rates. The table on the right is a projection of the total contributions to be made by the individual, on the basis of these rates.

Contributions to be made by self-employed	Entering age 1-1-60	Total taxes Payable to age 65
1960-62 4-1/2%	30	$10,692.00
	35	9,072.00
1963-65 5-1/4%	40	7,452.00
	45	5,832.00
1966-68 6%	50	4,212.00
	55	2,592.00
1969 and after 6-3/4%	60	1,152.00

These taxes are paid from "take-home" pay, as the payments are not allowable as "taxes paid" for federal income tax assessment.

Comment

"A State which dwarfs its men in order that they may be more docile instruments in its hands even for beneficial purposes will find that with small men no great things can really be accomplished."

G. F. Brockman, M.D.

ORGANIZATION SECTION

Jefferson County Medical Society Pioneers Study Group Program



Members of the Study Committee: Seated, left to right, Hoyt D. Gardner, M.D.; Daniel G. Costigan, M.D.; Robert C. Long, M.D.; Ed P. Jackson; James B. Douglas, M.D. Standing, left to right, Homer B. Martin, M.D.; Henry B. Asman, M.D.; C. Melvin Bernhard, M.D.; David M. Cox, M.D.; R. Burke Casper, M.D.; Everett H. Baker, M.D. George W. Pedigo, M.D., was not available at the time the picture was made.

COUNTY medical societies across Kentucky and the nation might well follow the lead of the Jefferson County Medical Society in setting up an active study group of dedicated physicians.

The purpose of forming such a group is twofold. First, to become informed on the current socio-medical economic and political issues relating to the medical profession and to the care-of-the-aged health issues. Second, to educate fellow physicians and the public about the issues involved.

The record thus far of this pioneer medical group is described by veteran medical leaders as a truly outstanding accomplishment.

Daniel G. Costigan, M.D., Louisville, president of the Jefferson County Medical Society in 1961, was the originator of the idea which led to the formation of the Study Group and Robert C. Long, M.D., Louisville, was the group's first chairman.

To quote, in part, from Doctor Costigan's address as retiring president of the Society January 15, 1962:

"Shortly after the first of the year when I took office a television program produced by CBS entitled CBS Reports was seen on one of our local television stations . . . The program was obviously edited to reflect to the disadvantage of the medical profession . . . One immediate result was a firm resolution on my part to form a committee whose purpose it would be to acquaint themselves with the facts concerning medical care for the aged. More specifically, to become educated on the whys and wherefores of this current piece of domestic legislation and having learned the facts, to present medicine's side of the story simply, truthfully and logically."

This was the beginning.

Doctor Costigan asked Doctor Long if he would head the group and Doctor Long agreed. Then began the long months of learning.

The group was small. This was intentional. Too large a group can be unwieldy and lose part of its effectiveness. It is limited to a selected group, originally 10, who were willing to devote time to this sphere of medicine outside their regular practice which all emphasize comes first.

Their aim in their early sessions was to study all they could about the socio-economic aspects of medicine as involved in the proposed plan of the federal government to put medical care of the aged within the scope of Social Security—first to learn and then be prepared to tell medicine's side of the story to other physicians and to the general public.

Each Assigned Topic

Each study group member was assigned a particular topic on which to prepare himself—such as Kerr-Mills, health insurance, legislation pertaining to the drug field, King-Anderson, Social Security, etc. Material was secured from all available sources. The American Medical Association and the Kentucky State Medical Association furnished much information. The State Health Department furnished some; Blue Cross and Blue Shield; transcripts of hearings on federal legislation such as the Forand Bill and King-Anderson Bill were studied. Material on the medical indigent and Kerr-Mills program in Kentucky was carefully reviewed.

The group practiced the art of presentation and good speaking habits were studied. At the sessions, two or three times a month, the group set itself up to criticize and question the member or members making the practice presentations. The aim—to share the material gathered and to help each prepare himself to make the best possible presentation of material and at the same time be prepared to answer any and all questions which might be directed to him by any audience.

In October of last year, the group sponsored in Louisville the television appearance of Edward R. Annis, M.D., Miami, Fla. He furnished the group not only with inspiration and enthusiasm for their task but with material for their study.

After six months of preparation the members felt ready to answer calls for speeches. They sent out letters to some 300 groups in the Jefferson County area asking for speaking engagements. To date about 40 such appearances have been made and more are being made each week. The doctors usually go in pairs. One makes an address of no more than 20 minutes; the other follows with a brief presentation and both are then ready to answer questions.

Address All Groups

Most study group members feel that it is equally important to address both lay groups such as men's clubs, parent-teacher associations, etc., and professional groups of physicians and allied fields. Some are concerned over the apathy and lack of knowledge of many doctors on the subject. They feel both the public in general and physicians, too, need to be informed and kept up to date on matters affecting the profession on the national level.

Audiences addressed were, on the whole, small groups. The average size would probably be about 75. Appearances were made at the KSMA Trustee District meetings. The group, together with several KSMA officers, met with Congressman Frank R. Burke for a lengthy discussion of the King-Anderson Bill. There were two debates before audiences.

One of the members debated on the radio with a labor leader.

Response both during and after meetings and as a result of such appearances was favorable without almost any exception. Such criticism as was heard by any member, and it was at the very minimum, came without fail from an individual with a personal problem or personal grudge against the profession from some real or fancied bad experience.

Members of the group were impressed with the cordial reception from all audiences and particularly the interested reaction from groups of elderly people, many of whom expressed their gratitude for the opportunity of hearing medicine's side of the story. Many said they had been unaware of the facts as they had previously only heard the Social Security approach to the problem.

The study group feels the program has been effective, helpful; that its complete contribution is difficult to measure. It is a continuing program. The new study group committee which includes the old committee plus one or two additions is headed by Doctor Costigan.

Plans for the future are to interest some lay people in the program. Another meeting is planned for April to which representatives of labor have been invited to present their side of the question and to hear the physicians' presentation.

Members feel that possibly they themselves have benefitted the most from the study which they have given to the problems confronting the medical profession. They know they have at least made a start in helping others become aware of these problems and in presenting medicine's side of the story to the profession and the public. They hope other groups will follow.

Surgeons Plan Full Program For Lexington Meeting

The Kentucky Chapter of the American College of Surgeons will hold its annual meeting March 16-17 in Lexington.

Guest speakers include the following: D. F. Ellison Nash, M.D., London, England, "Management of Carcinoma of the Breast, Particularly in Relation to Conservative Surgery"; Howard Patterson, M.D., New York City, "Surgical Lesions of the Right Colon"; R. L. Flocks, M.D., Iowa City, Iowa, "Carcinoma of the Prostate"; Willard M. Allen, M.D., St. Louis, Mo., "Operative Treatment for the Stein-Leventhal Syndrome"; Oscar P. Hampton, M.D., St. Louis, Mo.," Demands of Open Reduction of Fracture."

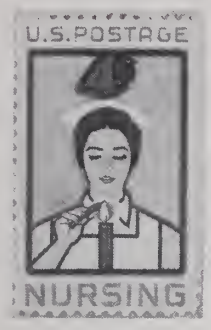
In addition, 11 chapter members will present papers.

The scientific sessions will be held at the University of Kentucky Medical School beginning at 9 a.m. March 16 in the University Hospital auditorium. Other sessions of the convention are to be held at the Phoenix Hotel. Special entertainment is planned for the ladies.

Surgical and operating room nurses from Kentucky are specially invited guests for Friday afternoon starting with a luncheon session at the Student Union Building on the U. of K. campus. There will be a tour of the new Medical Center hospital.

Commemorative Stamp Honors Nursing Profession

In connection with the issuing of the first four-cent stamp honoring the nursing profession, many ceremonies were held throughout Kentucky. The stamp was issued by the U. S. Post Office Department December 28.



Governor Bert Combs of Kentucky joined others in extending congratulations to the nurses of Kentucky in a message to Miss Marion M. Walters, R.N., medical supervisor at Louisville General Hospital.

Lieutenant Governor Wilson W. Wyatt participated in ceremonies at Lexington.

In Louisville, the stamp was presented to Miss Mary Schansberg, a student nurse at General Hospital representing the nursing profession, by William K. Keller, M.D., professor of psychiatry at the University of Louisville School of Medicine. Miss Schansberg presented the stamp to Louisville's mayor, William O. Cowger.

In other cities in the Commonwealth, ceremonies were held with participants including members of the nursing profession, mayors and postmasters.

Kentucky Hospital Association Plans Full Program for March 19-22

"Voluntary Hospitals—Democracy In Action" is the theme of the meeting of the Kentucky Hospital Association, to be held March 19-22 at the Kentucky Hotel, Louisville.

Addresses at the morning session, March 20, with the theme "Voluntary Hospitals—To Be or Not To Be"—will be given by John B. Reckless, M.D., Department of Psychiatry, Duke University, Durham, N. C., and by J. Ed McConnell, vice-president, Kentucky Blue Cross Hospital Plan, Inc. The afternoon session features a panel presentation of "Kentucky's Medical Care Program for the Indigent" with audience participation. Members of the panel are: Russell E. Teague, M.D., and staff, commissioner, Department of Health, Frankfort; Wade Mountz, administrator, Norton Memorial Infirmary, Louisville, and Earle V. Powell and staff, commissioner, Department of Economic Security, Frankfort.

Melvin L. Sutley, Philadelphia, past president, American College of Hospital Administrators, will address the breakfast meeting of the American College of Hospital Administrators Wednesday morning, March 21.

The theme of the general session Wednesday morning is "Community Partnership—That is the Answer." Speakers include: P. Booker Robinson, president, Citizens Fidelity Bank & Trust Co., Louisville, and Ben R. Brewer, administrator, Western Baptist Hospital, Paducah.

Seminars Wednesday afternoon will be concerned with: "Liability of Charity Hospitals," "The Total Hospital Safety Program" and "Extended Patient Care."

Louie Throgmorton, vice-president, Republic National Life, Dallas, Texas, will be the featured speaker at the Wednesday evening dinner meeting. The new president, Robert E. Selwyn, administrator, Harlan Memorial Hospital, Harlan, will be installed.

Thursday morning will feature inspection of exhibits and the president's report by Homer D. Coggins, administrator, Central Baptist Hospital, Lexington, and the executive director's report by Hasty W. Riddle, Louisville, executive director of the Association.

Entertainment including a golf tournament, hospitality hour, buffet supper and dance are scheduled for Monday, March 19.

Pediatricians to Hold Meeting At Frankfort April 18-19

The Kentucky Pediatric Society will meet at Frankfort April 18-19. On April 18 the Society will hold a joint dinner meeting with the Kentucky Chapter of the American Academy of Pediatricians at the Holiday Inn. Speaker for the joint meeting will be Alexander A. Weech, M.D., Rachford professor of pediatrics at the University of Cincinnati School of Medicine and director of the Cincinnati Children's Hospital Research Foundation.

On April 19 the Kentucky Pediatric Society will hold its meeting. In the morning there will be a handicap golf tournament at the Juniper Hill Golf Course or a tour of the new Kentucky Health Services Building for the non-golfers.

The scientific session begins at 2 p.m. in the Holiday Inn Ball Room. The program is as follows:

1. "An Approach to Convulsions in Childhood," Frederick A. Horner, M.D. 2. "Treatment of Dehydration in Pediatric Practice," C. Charlton Mabry, M.D. 3. "A Review of Human Cytogenics," Kenneth W. Dumars, Jr., M.D. All are from the Department of Pediatrics, University of Kentucky School of Medicine, Lexington.

The scientific session will be followed by the annual business session, a social hour and dinner.

The special plans for the ladies include, from 1 to 4 p.m., the Frankfort Boone tour of places of historical interest and a tea to follow at the Governor's Mansion.

Surgeons Plan Session

The Kentucky Surgical Society will meet May 25-26 at the Netherlands Hilton Hotel, Cincinnati, Friday, May 25. The University of Cincinnati School of Medicine will cooperate in presenting the scientific program. There will be surprise entertainment on that day. Complete details will appear in the April issue of The Journal.



Ernest B. Howard, M.D., assistant executive vice-president, American Medical Association, is shown addressing the Fifth Trustee District meeting of KSMA in Louisville, February 12. Presiding was Carlisle Morse, M.D., left, Louisville, Fifth District trustee.

Total of 1,060 Attend District Meetings in Two Months

A total of 15 Kentucky State Medical Association Trustee District meetings were held between January 9 and February 12. Reports on these showed a total of 1,099 attended these sessions. It is estimated that of the total attending, 652 were physicians. Average attendance at each meeting was 73.

Gaithel L. Simpson, M.D., KSMA president, attended four of these district meetings. He also was present at the meeting of specialty group presidents in Louisville, January 4, when plans were made for the 1962 Annual meeting program.

It was the KSMA Steering Committee, named by the Board of Trustees and headed by Doctor Simpson, which undertook the task of preparing the program for each of the District meetings. The Board of Trustees at its recent meeting passed an action thanking the speakers for their contribution of time and effort. Doctor Simpson also expressed his thanks to the members of the committee.

Senior Day To Be Held March 19; Auxiliary Plans Told

Featured speaker at Senior Day, March 19, will be Hebbel E. Hoff, Baylor University College of Medicine, Houston, Tex. Senior medical students at the University of Louisville will be guests of physicians at the session, starting at noon at General Hospital, with later sessions at the Medical Arts Building.

Senior Day is sponsored by the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine and the Jefferson County Medical Society.

The Women's Auxiliary plans a special program for wives and sweethearts of the medical students to be held at 7:30 p.m. Tuesday evening, March 20, at the Kentucky Hotel, Louisville. Carroll L. Witten, M.D., Louisville, will be the speaker. Mrs. James S. Rich, Lexington, president-elect of the Auxiliary, will preside. Some of the Auxiliary members will present a special program.

KSMA Dues Are Below Average in National Study

Annual dues paid by members of the Kentucky State Medical Association are $7 less, on the average, than those paid by members of 51 other state associations including Alaska, Hawaii and Puerto Rico. These figures are available as the result of a survey conducted by Ralph W. Neill, executive secretary of the Washington State Medical Association.

Of the 51 associations, members of 22 pay higher annual dues; 12 pay the same as Kentucky members and 17 pay less.

Medical association members in Nevada and South Dakota pay the highest dues, reported in the survey —twice as much as KSMA members. Next highest dues are paid in Iowa, New Mexico and Wisconsin.

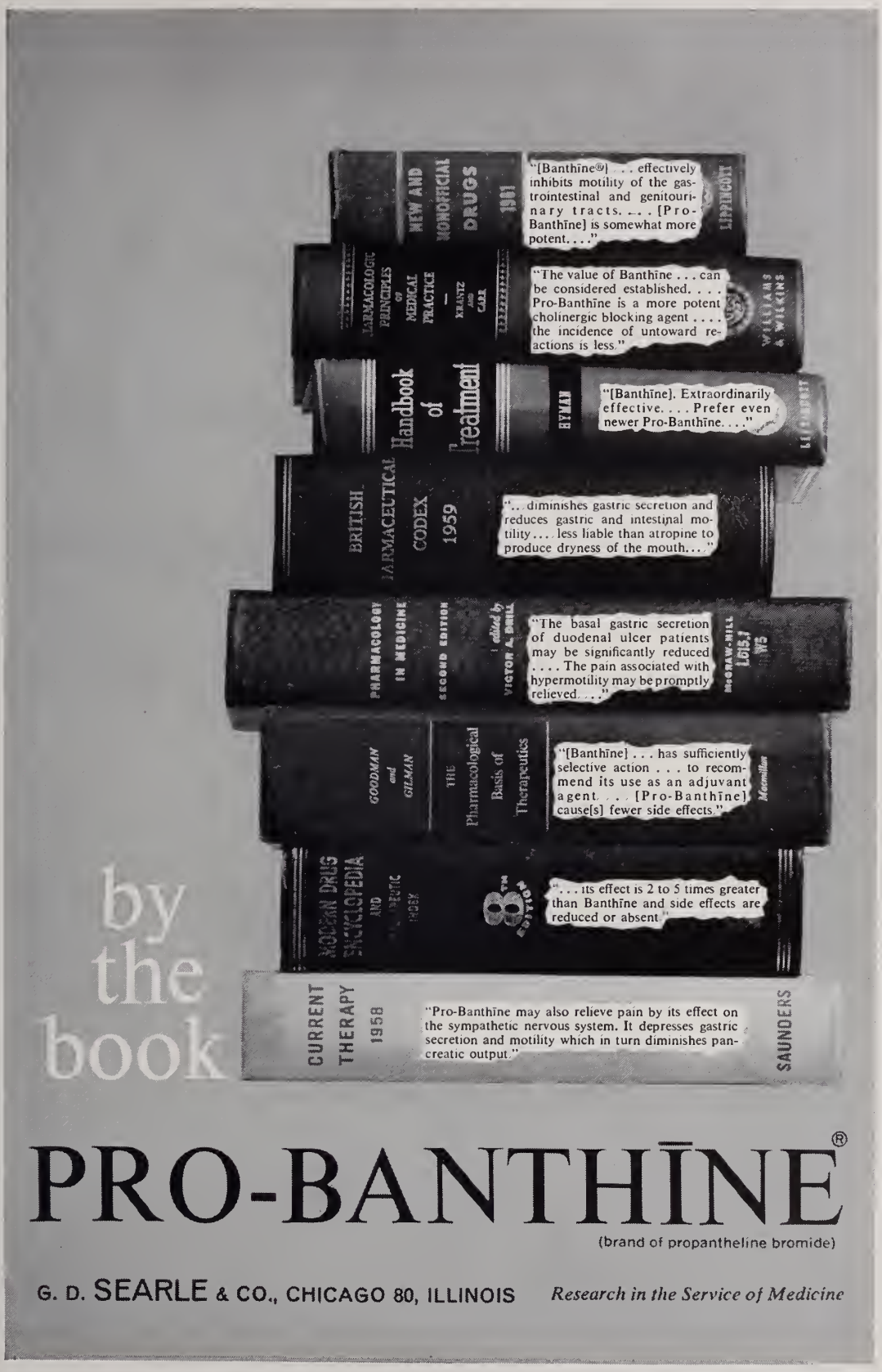
New Loan Program For Students Slated By AMA

The American Medical Association February 14 announced details of a new medical education loan program to offer financial assistance to medical students and doctors in residency and in internship training. The loan program, which will be opened up within a few weeks, will be a function of the AMA Education and Research Foundation. It will aid students at any stage of their medical training.

Financing of the program has been negotiated with the Continental Illinois National Bank and Trust Co., Chicago, for the present but will be extended to other large banks as the program progresses. The loans will be guaranteed against default by the AMA Education and Research Foundation.

Borrowers will be limited to $1,500 plus interest in any single 12-month period and $10,000 total in a seven-year period. By agreement, the cost at present during the educational period will be 5½% simple interest. No payments of principal and interest will be required during the training period. Notes will fall due five months after completion of the training period. In addition, borrowers may not be indebted for more than $15,000 for educational purposes from all sources.

The Kentucky State Medical Association through its Rural Kentucky Medical Scholarship Fund also has a program to assist medical students in Kentucky who need financial help and want to practice in the rural areas of the State. The Kentucky plan lends up to $1,000 per year to any medical student of both sexes without regard to race, creed or color at 2% simple interest. The term of each loan is seven years. Recipients of these loans who agree to practice in one of 10 Kentucky counties considered to be most in need of physicians at the time the recipients go into practice will be granted the cancellation of a year's loan for each year of practice in one of these counties.



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Dietitians Mark Special Week February 19-24

Throughout Kentucky during the week of February 19, members of the Kentucky Dietetic Association celebrated "Dietitians' Week.

The week of February 19-24 was proclaimed as "Dietitians Week" by Governor Bert T. Combs November 22, 1961. In his proclamation, the Governor pointed out that services of dietitians are needed in hospitals, schools and industrial plants and they contribute significantly to the health of individuals and families.

Members of the Louisville Dietetic Association toured Marine Hospital as part of their observance of the week.

Certifying Courses for KAGP Credit Explained

According to the by-laws of the American Academy of General Practice, a program may be certified for Category 1 credit only if some member of a state academy educational commission participates in the formation of the program, according to James W. Davis, M.D., chairman of the KAGP Commission on Education. He points out that this is the decision of the AAGP and that the Kentucky Academy must abide by these rules.

"The AAGP believes that since it is the only medical group requiring post graduate education for continuing membership, it should have some responsibility for the material presented to its members.

We of the Academy are forever grateful to all medical groups, specialties, medical schools, etc., which present to us first class programs and we only hope that they realize our position and therefore will help us comply with our responsibility to the constitution and by-laws of our organization."

Any group desiring Category 1 credit for their programs, should contact the KAGP headquarters office, Medical Arts Bldg., Louisville, to facilitate and expedite procurement of this credit.

Doctors Urged to Submit Questions About Blue Shield

The Professional Relations Committee, named last May from among Directors of the Kentucky Physicians Mutual, the Blue Shield Plan for Kentucky, by President John Dickinson, M.D., Glasgow, is urging physicians to submit questions about Blue Shield. The Committee, headed by Chairman B. B. Baughman, M.D., Frankfort, serves in a liaison capacity between doctors and Blue Shield.

Those questions submitted which are of general interest to the profession will be published on the "Answers to Questions About Your Blue Shield" page in The Journal of the Kentucky State Medical Association. A speakers' bureau of physicians is being formed and will be available to county societies or medical staff meetings on request.



John H. Bohlsen, right, 82, retired employee of the Ford Motor Company, Louisville, and member of Local 862, UAW-CIO, is presented a certificate by D. Lane Tynes, president of Blue Cross in Kentucky. The certificate represents the payment of $100,000,000 for care of members by Blue Cross in the State. More than 80,000 persons in Kentucky who are 65 years of age or more now have Blue Cross protection.

"Cooperation and understanding of voluntary prepayment is a must for the success and preservation of our free choice system, and to this end, we pledge our efforts," said Chairman Baughman. Other members of the Committee are: Ralph Lynn, M.D., Elkton; Wyatt Norvell, M.D., New Castle; W. Vinson Pierce, M.D., Covington; Robert W. Robertson, M.D., Paducah, and Garnett J. Sweeney, M.D., Liberty.

KSMA Dues Deadline Is April 1, Reminds President Simpson

Gaithel L. Simpson, M.D., Greenville, president of the Kentucky State Medical Association, points out in a friendly reminder to members that April 1 is the deadline for payment of 1962 dues. Doctor Simpson wishes to thank all those members who have already sent their county, state and AMA dues to the KSMA Headquarters office and requests the early cooperation of others.

Attention is called to Section 2, Chapter VIII of the 1961 Bylaws which reads: "Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met."

The address of the new KSMA Headquarters Building is 3532 Janet Avenue, Louisville 5, Ky.

A. Glenn Barton, M.D., a graduate of the University of Louisville School of Medicine in 1960, has opened an office in Louisville where he will be in general practice. A native of Memphis, Tenn., Doctor Barton took his internship training at SS. Mary and Elizabeth Hospital, Louisville.

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Textbook after textbook, article after article and experience in practice after practice consistently have demonstrated the capacity of Demerol to produce satisfactory analgesia without weakening the intensity of uterine contractions. In fact, many observers have reported an apparent shortening of labor, particularly in the primipara.

Because it is well tolerated by both the mother and the newborn child, Demerol is generally considered one of the safest analgesics for use in obstetric practice.

In addition to satisfactory analgesia, a moderate sedative effect is obtained with large doses, and sleep is frequently induced between pains.

In 13,000 deliveries reported by 158 physicians, "Demerol was unquestionably the narcotic of choice during labor."

(Questionnaire, The Maternal and Child Welfare Committee, South Dakota State M. A., 1958)[1]

"Demerol is our drug of choice for analgesia during labor."

(Posner, Fielding and Posner, Harlem Hospital, New York City)[2]

Demerol in combination with scopolamine ". . . offers the best means of securing analgesia and amnesia in labor with the least risk to the mother and child. . . . Often one is amazed at the manner in which the cervix melts away under this form of medication."

(Beck and Rosenthal, State University of New York)[3]





DEMEROL®

THE ANALGESIC OF CHOICE IN OBSTETRIC PRACTICE

Winthrop LABORATORIES • New York 18, N. Y.

DEPENDABLE ANALGESIA AND AMNESIA

Demerol with Scopolamine

"When combined with scopolamine, it [Demerol] can produce satisfactory amnesia-analgesia in over 90% of the mothers during labour."

(Hershenson and Reid. Boston Lying-in Hospital and Harvard Med. Sch.)[4]

In one of the most commonly used technics, an initial dose of 100 mg. of Demerol and 1/150 grain of scopolamine is given intramuscularly when labor is established. Subsequently, 100 mg. of Demerol are given every four hours and 1/200 grain of scopolamine every three hours. "Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished."

(Beck and Rosenthal)[3]

Demerol is "... an analgesic drug which relieves pain about as well as does morphine, and it has in addition an antispasmodic action which makes it a good preparation for use during labor. ... It may be given alone but its effect is enhanced when it is used in combination with scopolamine, and the resultant amnesic effect is excellent."

(Titus, Pittsburgh)[5]

SIDE EFFECTS AND CONTRAINDICATIONS: Demerol hydrochloride is generally well tolerated and nontoxic in therapeutic doses. Side effects occur more frequently in ambulatory patients (who should therefore be specially cautioned) than in those confined to bed. Dizziness is the most common reaction. Nausea or vomiting occurs less frequently than after administration of morphine. Flushing of the face, sweating and dryness of the mouth are sometimes noted. More severe reactions are characterized by great weakness, syncope, profuse perspiration, marked dizziness, and nausea and vomiting. They usually can be prevented if the patient lies down promptly at the onset of side effects. Tolerance to side effects usually develops quickly if medication is continued in small doses (25 mg.). In contrast to morphine, respiratory depression occurs infrequently. However, in patients with lesions that cause increased intracranial pressure, respiratory depression has been noted; therefore, the drug is considered to be contraindicated in such persons.

When Demerol with Scopolamine is used, idiosyncrasy to scopolamine may be encountered occasionally, producing the paradoxic effect of excitement, restlessness, hallucinations and delirium instead of sedation and amnesia. In addition, edema of the uvula, glottis and lips may be encountered occasionally in extremely hypersensitive patients.

Nalorphine (Nalline®) or levallorphan (Lorfan®) are considered to be specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics including Demerol.

1 Ranney, Brooks. *South Dakota J. Med. & Pharm.* 11:479, Dec., 1958
2 Posner, I. B., Fielding, W. L., and Posner, A. C. *Obst. & Gynec.* 2:81, July, 1953
3 Beck, A. C., and Rosenthal, A. H. Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Company, 1958, pp. 1029, 1030
4 Hershenson, B. B., and Reid, D. E. *Bull. Narcotics* 8:36, July-Sept., 1956
5 Titus, Paul. The Management of Obstetric Difficulties, ed. 5, St. Louis, C. V. Mosby Co., 1955, p. 617

PRINTED IN U.S.A. REVISED DECEMBER 1961 (LACDM)

DEMEROL Hydrochloride Solutions / *for Parenteral Use:*

50 mg. per ml.: Ampuls of 0.5, 1, 1.5 and 2 ml. (25 to 100 mg.); vials of 10 and 30 ml.; disposable syringes of 1 ml.

75 mg. per ml.: Disposable syringes of 1 ml.

100 mg. per ml.: Ampuls of 1 ml.; vials of 20 ml.; disposable syringes of 1 ml.

pH of Demerol 5% and 10% solutions in empuls and vials is adjusted between 4.5 and 6.0 with sodium hydroxide or hydrochloric acid. Multipla dose viels of Demerol solution also contain metacresol 0.1 per cent as preservative.

Demarol with Scopolamine (50 mg. of Demerol HCl and 1/300 grain of scopolamine HBr per ml.): Ampuls of 2 ml.; viels of 30 ml. pH is adjusted between 4 and 5 with sodium hydroxide or hydrochloric acid.

DEMEROL Hydrochloride / *for Oral Use:*

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Demerol hydrochloride tablets 100 mg.

Demerol hydrochloride alixir (50 mg. per 5 ml. teaspoon)—Pleasant banana flevor, nonelcoholic. Especially useful for children.

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Doctor White To Address Kentucky Public Health Group

Raymond L. White, M.D., director of environmental health and head of the Department of International Health for the American Medical Association, will be keynote speaker at the 14th annual meeting of the Kentucky Public Health Association, April 10-12 at the Kentucky Hotel, Louisville.

Doctor White will speak at 10:40 a.m. on the opening day of the meeting.

Other speakers and their subjects include: John O'Donnell, chief of psychiatric social service, U. S. Public Health Service Hospital, Lexington, "Narcotics Addiction Program"; John Dawes, state alcoholic control coordinator, "Alcoholic Addiction Programs"; Raymond A. Kemper, professor of psychology, University of Louisville, "Sociological Aspects of Addiction"; Russell E. Teague, M.D., Kentucky health commissioner, "The Broad Horizon of Community Health."

Radioactivity and venereal disease programs are slated.

Governor Bert T. Combs will address the Wednesday evening banquet.

Hill-Burton Provides $60 Million For Kentucky Projects

One-half the cost of construction of hospitals and medical centers has been provided in Kentucky by federal funds since passage of the Hill-Burton Act in 1946. Total cost of such construction is $121,594,-714.18.

Hill-Burton funds, which provided 50% of the amount spent, are administered in Kentucky by the Division of Hospital and Medical Facilities of the State Health Department. Paul A. Hackney is division director. The total covers projects completed, both new and additions; projects under construction and projects in the planning stage already earmarked as eligible for federal money.

Completed in the State since the act was passed are 57 public health centers, 32 general hospitals, a mental hospital, a tuberculosis hospital, two chronic-disease hospitals, four schools of nursing, three nursing homes and a diagnostic and treatment center.

Other projects include additions at 34 general hospitals, four mental hospitals, a tuberculosis hospital, two schools of nursing, a system of laboratories in the State Health Department building, a new steam plant at the University of Kentucky Medical Center and equipment for five tuberculosis hospitals.

Now under construction are five new general hospitals, seven general hospital additions, one tuberculosis hospital addition, 13 new health centers and a new diagnostic and treatment center and rehabilitation center at the University of Kentucky Medical Center.

Planned projects include: eight new general hospitals, 10 general-hospital additions, three health centers, a new diagnostic and treatment center, three new nursing homes and two new rehabilitation centers.

On February 9 Doctor Seaborg addressed a joint session of the Kentucky Legislature at Frankfort, calling attention to the signing in Washington as "a noteworthy one for several reasons and many precedent setting 'firsts' were again established to the credit of this Commonwealth."

He pointed out in his address that the AEC supports work at the University of Kentucky, University of Louisville, Morehead State College, Western Kentucky State College, Ursuline College and the Kentucky Research Foundation.

Faculty, Residents in Ready Reserve Asked to Seek Transfer

The National Advisory Committee to the Selective Service System, following a December meeting, suggested to deans of schools in the health professions that faculty members and those in residency programs who are now in the ready reserve be asked to submit resignations and ask transfer to the standby reserves.

The Committee also suggested that residents receiving "1-A Examined and Acceptable" classifications appeal such classifications to the Selective Service System appeal board in the area in which they are serving their residency. Such appeals should be supported by statements from hospital authorities as to the essentiality of the resident to the patients of the individual completing that particular year of residency, be it first, second or third.

Students and interns in ready reserve units in such capacities as pilots, etc., are urged by the Committee to ask for transfers to the early commissioning program.

These suggestions, the committee points out, are made in an effort to evaluate the needs of both the military and civilian institutions. The military is anxious to determine the strength of its ready reserve, and civilian institutions should determine what a call-up of ready reserve units would mean to them so they may adjust their planning and be prepared for a sudden notice of loss of ready reserve units members.

Combs Suggests Waverly Become State Home For Aged

Following a tour of Waverly Hills Sanatorium, Louisville, February 18, Kentucky Governor Bert T. Combs said he and Harold L. McPheeters, M.D., State mental health commissioner, had agreed that the administration building at the hospital could be used as a State home for the aged. The Sanatorium was closed as a tuberculosis hospital last June.

Governor Combs appointed a committee to negotiate with the Louisville and Jefferson County Board of Health, owner of the property. He said plans call for floating a bond issue to buy the hospital.

The Governor said that if and when the property is acquired by the State a non-profit organization would be set up to operate the home in order to qualify residents for federal and State old-age assistance. The money would be used to retire the bonds.

OPPORTUNITIES

From The

KSMA Postgraduate Medical Education Office

In Kentucky

MARCH

20-22 Kentucky Hospital Association, Louisville, Ky.

28-29 Jefferson County Chapter, American Heart Association, Louisville, Ky.

APRIL

5 *POSTGRADUATE COURSE - DERMATOLOGY, Jewish Hospital, Louisville, Ky.*

10-12 Kentucky Public Health Association, Louisville, Ky.

10 through MAY 29 *POSTGRADUATE COURSE - PEDIATRICS, Louisville Children's Hospital, Louisville, Ky., Tuesday mornings.*

18-20 Kentucky Tuberculosis Association, Annual Meeting, Louisville, Ky.

19 Kentucky Pediatric Society, Frankfort, Ky.

25 Kentucky Psychiatric Association, Semi-Annual Meeting, Lexington, Ky.

MAY

1-29 *POSTGRADUATE COURSE - PEDIATRICS, Louisville Children's Hospital, Louisville, Ky., Tuesday mornings.*

9-11 *Kentucky Academy of General Practice, Annual Scientific Meeting, Louisville, Ky.*

17 Benjamin Felson, M.D., "Fundamentals of Cardiac Roentgenography," University of Kentucky Medical Center, 7:30 p.m.

17-18 Kentucky Obstetrical and Gynecologic Society, Gabe's Restaurant, Owensboro, Ky.

JUNE

7 KAGP Seminar, Harrodsburg, Ky.

14 KAGP Seminar, Country Club, Henderson, Ky.

Surrounding States

MARCH

22 Postgraduate Course, **"Common Pediatric Surgical Problems"** Vanderbilt University School of Medicine, Nashville, Tennessee.

22-24 Central Surgical Association, Cincinnati, Ohio.

26-28 American College of Surgeons Sectional Meeting, Memphis, Tennessee.

29-30 Postgraduate Course, **"Otolaryngology,"** University of Tennessee College of Medicine, Memphis, Tennessee.

APRIL

1-4 American College of Obstetricians & Gynecologists, Chicago, Illinois.

5-7 Postgraduate Course, **"Electrocardiography,"** University of Virginia School of Medicine, Charlottesville, Virginia.

6-12 American Academy of General Practice, Annual Meeting, Las Vegas, Nevada.

6-8 American Society of Internal Medicine, Philadelphia, Pennsylvania.

9-13 American College of Physicians, Philadelphia, Pennsylvania.

23-28 American Academy of Neurology, New York, New York.

25-26 Postgraduate Course, **"Dermatology,"** University of Tennessee College of Medicine, Memphis, Tennessee.

MAY

2-4 Postgraduate Course, **"Orthopedics,"** University of Tennessee College of Medicine, Memphis, Tennessee.

7-11 American Psychiatric Association, Toronto, Ontario, Canada.

10-11 American Pediatric Society, Atlantic City, New Jersey.

14-17 American Urological Association, Philadelphia, Pennsylvania.

20-25 National Tuberculosis Association, Miami, Florida.

23-25 Postgraduate Course, **"Psychiatry,"** University of Tennessee College of Medicine, Memphis, Tennessee.

24 Postgraduate Course, **"Inter-Relationships of the Mental Hospital and the Psychiatric Problems of Medical Practice,"** Vanderbilt University School of Medicine, Nashville, Tennessee.

28-30 American Ophthalmological Society, Hot Springs, Virginia.

31-June 2 American Gynecological Society, Hot Springs, Virginia.

Joseph A. Little, M.D., Louisville, associate professor of pediatrics at the University of Louisville School of Medicine and physician-in-chief at Children's Hospital has been certified by the sub-board in pediatric cardiology. He is the only physician in Kentucky to hold this honor.

Grants to Two Medical Schools Total $263,942

Medical and dental schools at the University of Kentucky, Lexington, and the University of Louisville are scheduled to receive federal research grants totaling $263,942, according to an announcement January 12. The Medical School at the U. of L. will get $148,363, which, according to its dean, J. Murray Kinsman, M.D., will go to buy equipment for the Medical-Dental Research building under construction at the Medical Center.

The U. of L. Dental School will receive $31,501.

At the U. of K., the College of Medicine will get $55,328 and the Dental School, $28,750.

The City-County Health Department, Louisville, has received a $9,495 grant from the U. S. Public Health Service, to be used for its tuberculosis-control program. Thomas S. Wallace, Jr., M.D., acting health director, said the grant was for the first six months of 1962 and would provide for the hiring of three public health nurses to specialize in tuberculosis field work in Jefferson County and Louisville. Doctor Wallace said he hopes the grant will be renewed for 12 more months.

Ulrich F. Westphal, member of the faculty of the U. of L. Medical School, February 8, received the Career Research Award of the federal government. He will use it to continue his research in hormones and proteins. Doctor Westphal holds degrees from Universities of Goettingen and Berlin and received his doctorate in philosophy from the University of Tuebingen, all in Germany.

Frank Falkner, M.D., was named acting chairman of the U. of L. Medical School pediatrics department effective February 1. Doctor Falkner, an associate professor of child health at the school, is a native of London, England; is a member of the Royal College of Physicians.

Milton Comer, M.D., and Harry Douglas Stambaugh, M.D., have been named instructors in surgery; Xuan Truong, M.D., instructor in physical medicine and rehabilitation, and Thomas R. Marshall, M.D., instructor in radiology—at the U. of L. School of Medicine.

U. of K. College of Medicine

Recent appointments to the staff of the University of Kentucky College of Medicine include the following:

Letizia C. Ciaramelli, M.D., named instructor of clinical psychiatry. He is presently on the staff of the Veterans Administration Hospital at Lexington.

Irving A. Gail, M.D., named associate professor of clinical psychiatry. Doctor Gail is in private practice in Lexington.

Mervyn B. Quigley, D.M.D., M.S., appointed associate professor of anatomy in the College of Medicine and associate professor of oral surgery in the College of Dentistry. He was formerly assistant professor of anatomy at the University of Alabama Medical School.

John H. Rompf, M. S., named assistant professor of clinical psychiatry. Doctor Rompf is in private practice in Lexington.

Torkel Scholander, M.D., named visiting professor of psychiatry. He is assistant chief of the Clinic of Child Psychiatry, University of Upsala, Sweden.

Carl Wiesel, M.D., appointed associate professor of clinical psychiatry. Doctor Wiesel is in private practice in Lexington.

Abraham Winkler, M.D., appointed professor of clinical psychiatry. He is chief of the section on Experimental Neuropsychiatry, National Institute of Mental Health Research Center, Public Health Service Hospital, Lexington.

List of Fall Out Shelter Supplies Available in Kentucky

A list of first aid supplies for use in a fall out shelter has been prepared and is now available to physicians in Kentucky.

William T. Rumage, M.D., Louisville, chairman of the Kentucky State Medical Association Emergency Medical Services Committee, released the list which was compiled by the Committee. Charles F. Rosenberg of the Jefferson County Academy of Pharmacy and E. M. Josey, executive director of the Kentucky Pharmaceutical Association, assisted in preparation of the list.

The list may be obtained by writing to the KSMA Headquarters Office, 3532 Janet Avenue, Louisville 5, Ky. The EMS Committee has already filled numerous requests for the list made by people living in all sections of Kentucky.

Doctor Rumage said, "It should not be necessary to expect a military distaster before purchasing the items on this list. It would be desirable, we feel, for every family in the Commonwealth to have these supplies available in case of any emergency."

V.A. Outpatient Clinic May Move To Louisville V.A. Hospital

According to Veterans Administration officials in Washington, plans may be drawn to consolidate the Outpatient Clinic at 1405 W. Broadway, Louisville, with the general medical and surgical hospital on Zorn Avenue in that city.

Such a move would require approval of the Bureau of the Budget as well as that of Congress and it would be a matter of at least two years before complete plans would go to the Bureau of the Budget. If this were to happen, work might get started on the project in 1964.

George J. Van Besien, M.D., is director of the Louisville Outpatient Clinic.

Veterans Hospital has a staff of about 20 full-time doctors and 30 resident physicians in specialist training. The residency program is affiliated with the University of Louisville School of Medicine.

Academy to Meet

The Kentucky Academy of General Practice will hold its 11th annual scientific assembly May 9-11 at the Kentucky Hotel, Louisville. Complete details will appear in the April issue of The Journal.

Student AMA

University of Kentucky

Student Cubicles Appreciated

After a year and one-half of classes the feature of the University of Kentucky Medical Center that the students have appreciated and used more than any other is the study cubicle area.

For those who haven't seen the Medical Center, each student is assigned a study carrell which contains a desk, locker, filing cabinet, book case, fluorescent reading light and an electrical outlet. These compact metal units are housed in a 120 by 45-foot room on the first floor of the medical science wing.

The day incoming students register for medical school they are assigned to the cubicles that will be their home for the next two years, after which they will move to similar areas in the hospital for the clinical years.

The cubicles, or cells—as they are sometimes referred to around exam time—see steady use for studying and reading, or just relaxing. It is an odd hour on a long weekend when none of the study lights are burning. Some of the late sleepers even equip their cubicles with coffee pots and electric razors, just in case. A shower room, which adjoins the cubicle room, adds more of the comforts of home.

The students are indebted to Dean William R. Willard, M.D., who got the idea from the University of Florida Medical School and brought it to Kentucky.

Until now, only these two medical schools have individual study areas of this type for their students, but if the experience here is any measure of their success, I look for similar areas to be an integral part of new medical schools being built throughout the nation.

Joe C. Christian, President
University of Kentucky SAMA

University of Louisville

Medical Care Program

I recently saw depicted by cartoon in a national newspaper published by the American labor unions, the current stand being taken by organized labor on behalf of the present administrative program for medical care for the aged. In the drawing, Congress was shown as the kindly "father" offering to the aged and infirmed the proverbial "40 acres and a mule" in the form of "free" medical care. In contrast to this glowing picture, the AMA was cast as a vicious money grabbing, obese, gold watch chained titan, eager only to get more for itself with no concern for the aged. Of course the cartoon, from the viewpoint of one remotely conscious of medical practice and ethics, was vile and revolting. But to the aged and oft ill "senior citizens" the scene was very acceptable.

So much discussion and political maneuvers have ensued since the threat of "socialized medicine" began to stalk America, that one is at a loss to understand who is trying to benefit what. The crux of the problem, at least at the moment, seems to rest with medical problems of the aged. It is for their interest that governmental effort seems to be exerting itself. It is felt that because of enormous burden of debt which medical care may place upon these persons something ought to be done to help. Onto this bandwagon have jumped labor, government and almost every other organization, including many hospital associations, and the National Association of Registered Nurses. They point an accusing finger at American medicine as if to condemn it for neglect and lack of concern for the health of everyone.

The problem which seems so very plainly to exist is a direct result of the struggle which doctors of medicine have already made on behalf of all ages of mankind. To use a pat medical student phrase "we have stamped out disease today." Well, not entirely but enough so that people are living much longer than ever before. What a diabolical situation! The very group which has made it possible for there to be an "aged" citizenry is now being accused of lack of care and interest in these people, even to the extent of bringing financial hardship upon them.

A logical solution will yet be a while in coming. Medicine earnestly desires the welfare of all people as we have reason to believe our federal government does also. The two groups and all others truly concerned need to recognize that we now have a population of older people, that this will continue to be so and that it is a result of the stupendous task performed by the earlier generations of physicians nourished by the freedom of a great country.

In this atmosphere, the solution will eventually come. But it will be hastened even more if cooperation rather than antagonism on both sides occurs.

We do not want a system of socialized medicine because we earnestly feel that this is not the best method of medical care for America's people. We then must, in a manner and spirit of cooperation, work to show our federal government which *is* the best way to care for the American people. The reward of such labor should prove to be a stronger and more healthy country for all.

Olson Huff, President
University of Louisville SAMA

Doctor Hall Is Dead

Edmund K. Hall, Ph.D., professor of anatomy at the University of Louisville School of Medicine, died in Norton Memorial Infirmary, Louisville, January 28. He was 59 years of age.

Doctor Hall went with the U. of L. Medical School in 1932 and spent his entire teaching career at that institution. During the last several years he had been studying the effects of drugs on embryonic hearts. Over the years he received several grants to help finance his research, including those from: the U.S. Public Health Service, the American Cancer Society and the National Science Foundation.



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Columbia Auditorium — **Louisville, Kentucky** — **September 18, 19, 20**

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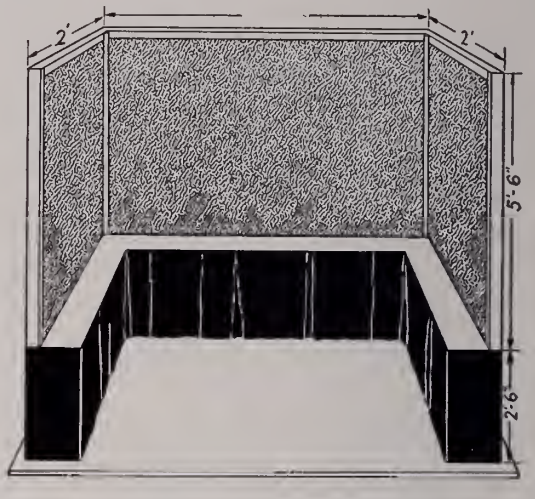
Committee on Scientific Exhibits

Heyburn Building,

Louisville 2, Kentucky

Applications for space should be received before July 1, 1962

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank, not to exceed 100 words, which will be used in the program.)

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Advisory Committee to the Editor

George F. Brockman, M.D., Chairman

Louisville **February 15, 1962**

The meeting of the Advisory Committee to the Editor was held in the new KSMA Headquarters Office Building.

A suggested list of replacements to the Board of Consultants for those with terms expiring July 1, 1962 was approved.

Plans for the next symposium edition of The Journal were discussed. The subject will be "Acute Infectious Diseases." Beverly T. Towery, M.D., Louisville is symposium editor.

A dedication issue of The Journal with ideas as to what should be included was a topic for discussion.

A change in the front cover design was approved.

Council on Medical Services

Claude C. Waldrop, M.D., Chairman

Louisville **January 4, 1962**

The KSMA Council on Medical Services held its first meeting of the associational year Thursday, January 4, at the Brown Hotel, Louisville.

Referrals from the 1961 House of Delegates were discussed by this Council and directed to the proper committees for implementation.

The Council also heard and discussed reports from each committee under the Council. Some recommendations concerning this year's programs were passed on to the committees and the headquarters officer for implementation.

Other topics discussed included the need for a benevolent fund for KSMA members and the selection of a committee to study further the matter of medical discipline.

Medicare Review Committee

McHenry S. Brewer, M.D., Chairman

Louisville **January 9, 1962**

The Medicare Review Committee held a meeting Tuesday, January 9, at the Brown Building, Louisville, to discuss methods and procedures following in processing Medicare cases referred to the Medicare Review Committee by Kentucky Physicians Mutual, Inc.

Three members of Kentucky Physicians Mutual, Inc.—Don Cherrie, Dave Greenwell and Mrs. Ruby Laws—attended the meeting to give their suggestions and offer advice on handling special cases.

The Committee passed two recommendations, one on Committee membership and the other on adoption of a new operative procedure.

Senior Day Committee

Carl C. Cooper, M.D., Chairman

Louisville **January 11, 1962**

The KSMA Senior Day Committee met on January 11 at the Brown Hotel, Louisville, to plan for the annual Senior Day program.

Hebbel E. Hoff, M.D., professor of physiology at Baylor University College of Medicine, Houston, Texas, was selected as the dinner speaker. The program is set for March 19.

The opening session will begin at 12 noon in the Rankin Amphitheatre at Louisville General Hospital. The afternoon session, which will be held this year in the Medical Arts Building, will begin at 2:30 p.m.

Senior Day is sponsored by the KSMA in cooperation with the Jefferson County Medical Society and the University of Louisville School of Medicine. The County Society is host to the seniors at the evening session which begins with a social hour at 6 p.m. and dinner at 6:45 p.m.

All KSMA members are invited.

School Health Committee

R. E. Davis, M.D., Chairman

Lexington **January 18, 1962**

The School Health Committee met January 18 at the Campbell House Hotel, Lexington, to plan, among other things, this year's athletic injury prevention conferences.

The Committee recommended that this year's program include several regional conferences on a statewide basis. In addition to the athletic injury prevention conferences for coaches, trainers, principals and teachers, a series of meetings for physicians may be planned so that physicians may become better informed in this area.

The Committee also discussed the circulation of safety pamphlets for high schools and the youth physical fitness program in schools in Kentucky.

All physicians interested in the medical aspect of sports are asked to contact the KSMA Headquarters office or R. E. Davis, M.D., Central City, chairman of the KSMA School Health Committee.

Council on Medical Education and Hospitals

Walter S. Coe, M.D., Chairman

Louisville **December 21, 1961**

The KSMA Council on Medical Education and Hospitals met for the first time during this associational year December 21 at the Brown Hotel, Louisville.

Several referrals from the 1961 House of Delegates were discussed and directed to the proper committees under the Council for implementation.

The Council also discussed methods of implementing present programs of committees under the Council and made some recommendations concerning new programs.

Three recommendations were made to the KSMA Board of Trustees.

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In Memoriam

OWEN PIGMAN, M.D.
Whitesburg
1877-1962

Owen Pigman, M.D., Whitesburg, died February 14 in a Lexington hospital. Doctor Pigman graduated from the University of Louisville School of Medicine in 1907. He was 85 years of age.

Doctor Pigman was active in Letcher County and Kentucky State Medical Association activities. He is survived by his wife, Percie, and a son, Carl Pigman, M.D., also a Whitesburg general practitioner. He received the KSMA outstanding General Practitioner Award in 1957.

MARC J. REARDON, M.D.
Covington
1916-1962

Marc J. Reardon, M.D., Covington, died at St. Elizabeth's Hospital, Covington, of a kidney ailment after undergoing surgery. Doctor Reardon was graduated from the University of Cincinnati College of Medicine in 1942.

He was president of the Kentucky Heart Association and had also been president of the surgery staff of St. Elizabeth's Hospital.

Doctor Reardon served his internship at Good Samaritan Hospital and surgical residencies at the University of Virginia and Duke Hospital before he began practice in northern Kentucky.

ALFRED WILLIAM ANDREASEN, M.D.
Danville
1900-1962

Alfred William Andreasen, M.D., Danville, died in his sleep February 20 apparently of a heart attack in the duty room of Kentucky State Hospital. Doctor Andreasen was graduated from the Kansas City University of Physicians and Surgeons in 1941. He joined the Kentucky State Health Department in 1950 as Pulaski County health officer and transferred to Kentucky State Hospital in 1956.

Doctor Andreasen held a reserve commission as lieutenant in the U. S. Public Health Service.

TOLBERT BOWMAN GINN
Vanceburg
1880-1962

Tolbert Bowman Ginn, M.D., Vanceburg, died January 9 at the Oaks Nursing Home at Maysville. Doctor Ginn graduated from the Kentucky University Medical Department, Louisville, in 1906. He had practiced medicine at Vanceburg for many years. He retired about three years ago.

OLIVER MALLORY REYNOLDS, M.D.
Louisville
1884-1962

Oliver Mallory Reynolds, M.D., Louisville, died January 4 at his home at 2407 West Chestnut. Doctor Reynolds graduated from Meharry Medical College at Nashville, Tenn., in 1909 and had practiced in Louisville for more than 50 years.

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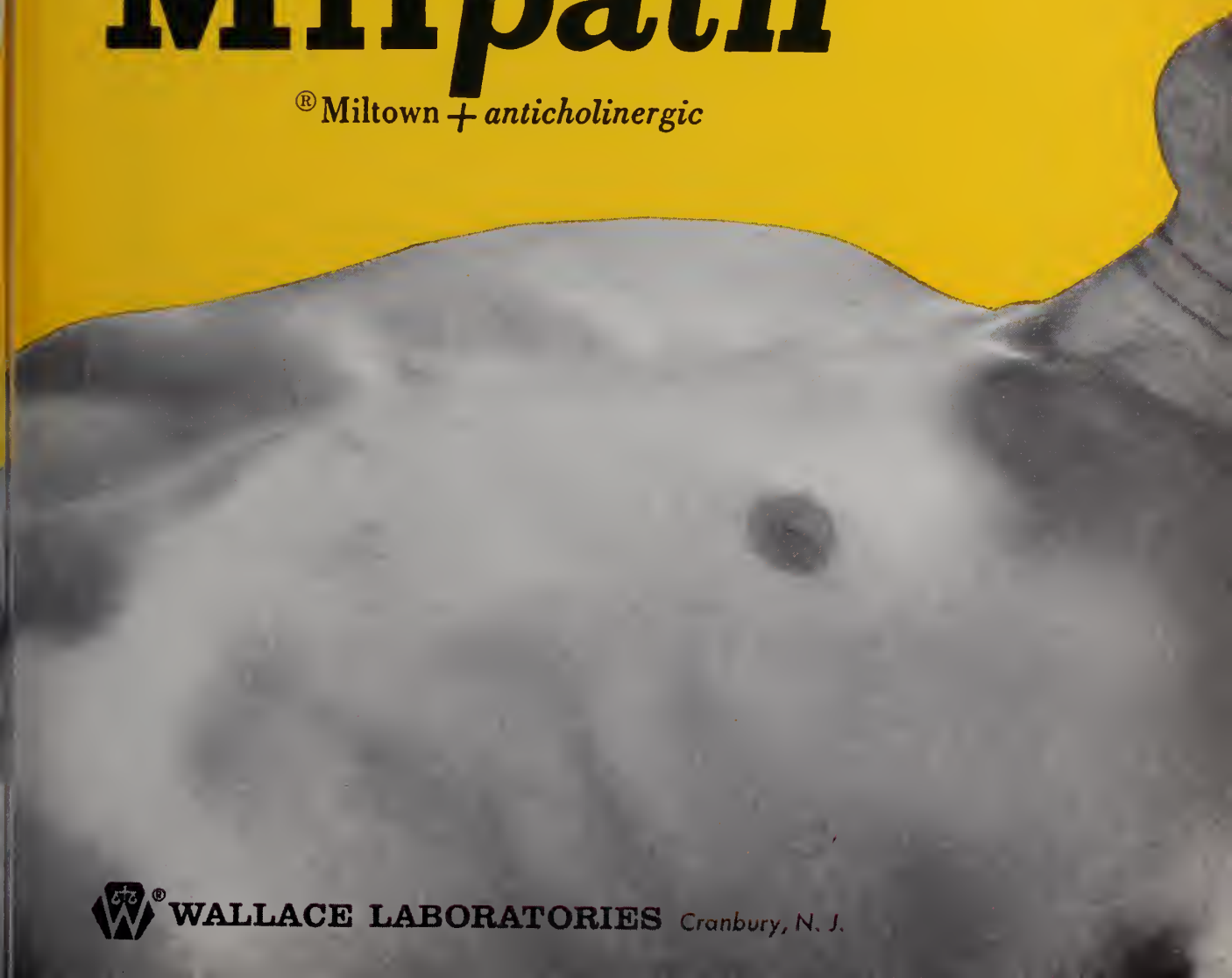
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McCracken County

Frank Spencer, M.D., associate professor of surgery at the University of Kentucky Medical Center, Lexington, made the featured address on "Newer Concepts of Treatment for Cardiac and Respiratory Arrests" at the January 24 meeting. The speaker was introduced by O. L. Higdon, M.D.

J. V. Pace, M.D., president of the Association, presided at the business session. W. P. Hall, M.D., and William W. Myre, M.D., were elected to three year terms on the executive committee.

A communication concerning the Self-Help Medical Care Plan was referred to the executive committee. The Society has already gone on record as approving this plan and the question of distribution of the plan locally has been referred to the committee.

A motion of Clarence Sullivan, M.D., to refer the question of the possible admission of local colored physicians to the Society was passed and referred to the executive committee for study.

Formation of a medical library at Lourdes Hospital was announced by Doctor Sullivan.

Theodore T. Myre, M.D., requested that the Society take some action to obtain group coverage under Blue Cross and Blue Shield.

Donald L. Boucher, M.D., made a motion, seconded by Harold D. Priddle, M.D., and passed, that a C-P-C type conference on patients as concerns diagnosis, methods of treatment, results, etc., be started at one or both of the local hospitals. President Pace appointed the following C-P-C committee to study the problem and meet with the executive committee: Doctor Boucher, chairman; Walter R. Johnson, Jr., M.D.; Frank B. Crawford, M.D.; Doctor Priddle; D. D. O'Sullivan, M.D.; William H. Smith, M.D.

Harlan County

The new president of the Harlan County Medical Society is T. Garrett Craft, M.D., Harlan. Other new officers are: Vice president, James D. Foley, Loyall; secretary-treasurer, William H. Potter, M.D., Harlan; delegates to the Kentucky State Medical Association, E. M. Howard, Jr., M.D., and David McLean Greeley, M.D., both of Harlan.

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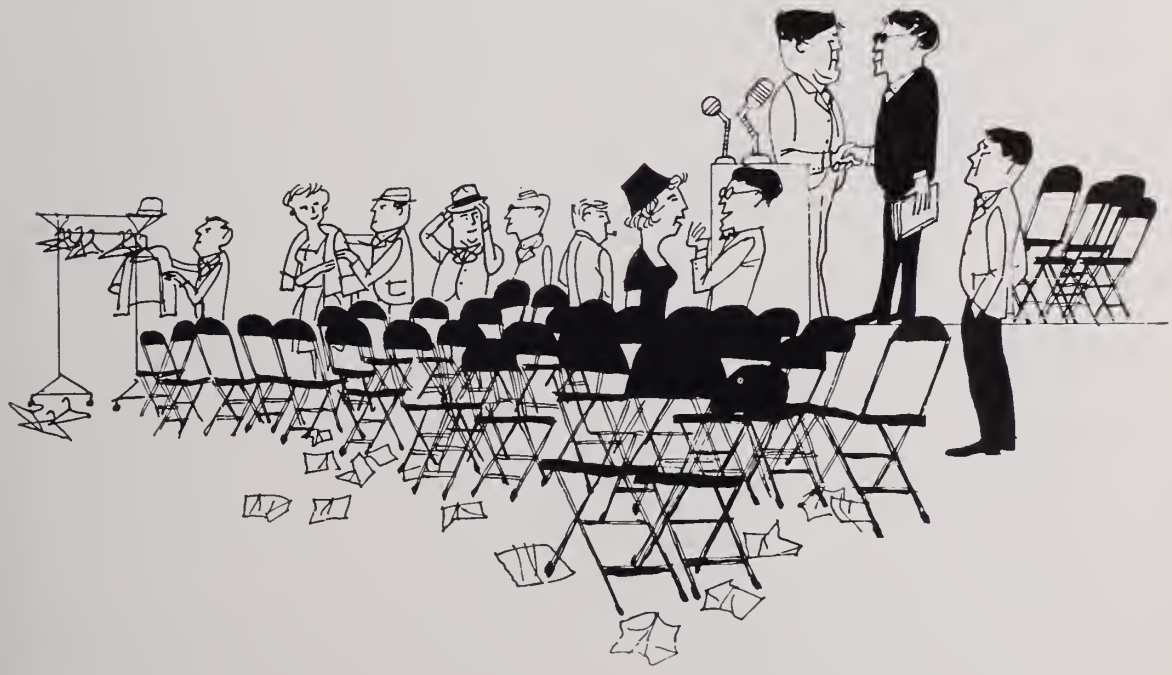
But now we wonder . . . because so many of you have said to us lately, either orally or in writing, "Why are you telling <u>us</u> this? Our patients are the ones who really need to hear this story."

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IN THE BOOKS



PRACTICAL PEDIATRIC DERMATOLOGY; by Morris Leider, M.D.; published by The C. V. Mosby Co., St. Louis, Mo.; 437 pages; price $13.75.

This is the first book on dermatology that limits its scope to the pediatric age group. The author stresses the practical aspect of the book and mentions in the preface that no exhaustive volume on pediatric dermatology was intended. Tables and charts are used very effectively for condensing and outlining material and yet the most of the book is very readable.

The proper use of the various topical medications is well covered in the chapter on principles of dermatologic therapy. This is followed by an adequate formulary that is easily located by the green color of the pages. Therapy is rational and the reader is repeatedly reminded of the importance of treating the dermatitis according to the stage of the inflammation.

The common sense approach to the management of atopic dermatitis is one of the outstanding sections of the book. The views so well expressed by the author on this difficult subject represent the consensus of most dermatologists.

The book is an excellent, concise textbook of dermatology and the material presented is sound. There is a duplication of many dermatoses that are basically the same in the child as in the adult, but perhaps this is unavoidable if the text is to be complete.

Practical Pediatric Dermatology is highly recommended to pediatricians as a standard dermatology textbook and to dermatologists as a supplementary textbook.

William H. Gillespie, M.D.

DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION; by Eliot Corday, M.D., and David W. Irving, M.D.; published by W. B. Saunders Co., Philadelphia and London; 357 pages; price $8.50.

This book is written for medical students and clinicians according to the authors. This reviewer feels they have fulfilled their intention well.

The book is divided into short chapters which makes for easy reading. The index is functionally good for looking up the answer to clinical problems regarding cardiac rhythm. Many diagrams are included to illustrate features of cardiac arrhythmias.

The subject of the book is cardiac arrhythmias—clinical symptoms and signs, EKG changes and treatment. This is not a reference book for the last word on theory in arrhythmias though some theory is included and a large number of references are included.

A chapter is included on bedside diagnosis of arrhythmias which is full of gems. Another fairly unique chapter deals with emotional factors in cardiac arrhythmias.

Of great interest to all will be information on hemodynamic effects of arrhythmias on flow to vital organs. The results of vasopressor therapy of arrhythmias are included, a technique recently repopularized by Doctor Corday and his group. These investigators have demonstrated conversion of both atrial and ventricular arrhythmias to sinus rhythm with pressor agents alone. Furthermore, they have demonstrated that the effect is not dependent on an intact vagus nerve. Levophed was found to be the most efficacious of the vasopressors.

This book is recommended for use by clinicians and medical students alike in the diagnosis and management of the patient with cardiac arrhythmia.

Charles C. Smith, M.D.

APPRAISALS OF CURRENT CONCEPTS IN ANESTHESIOLOGY; edited by John A. Adriani, M.D.; published by The C. V. Mosby Company, St. Louis, Mo.; 279 pages; price, $7.75.

This timely treatment of several general problems of interest to all anesthesiologists has been very thoroughly reviewed from the existing literature. There are 45 chapters each with a different area of interest to all anesthesiologists.

The brief, but very informative treatment of this material will bring any anesthesiologist up to date in a very short period of time if he has been doing collateral reading in the same field of review. There has been very little injection of personal opinion by the various authors in the Journal Review Club from the Adriani group in this publication. It is outstanding in that it deals particularly with factual material and not with personal opinion. However, in a few areas, personal opinion has crept into the writing, such as the time honored and very reliable fact that a physician should use the equipment and methods he is most familiar with in producing good results for his patient and that if a physician strays from the path into something that is new to him, it might very well be fatal to his patient.

The variety of subjects that come under scrutinization and review by Doctor Adriani's capable panel of contributors is very complete and they are to be highly commended in their treatment of the material from the literature.

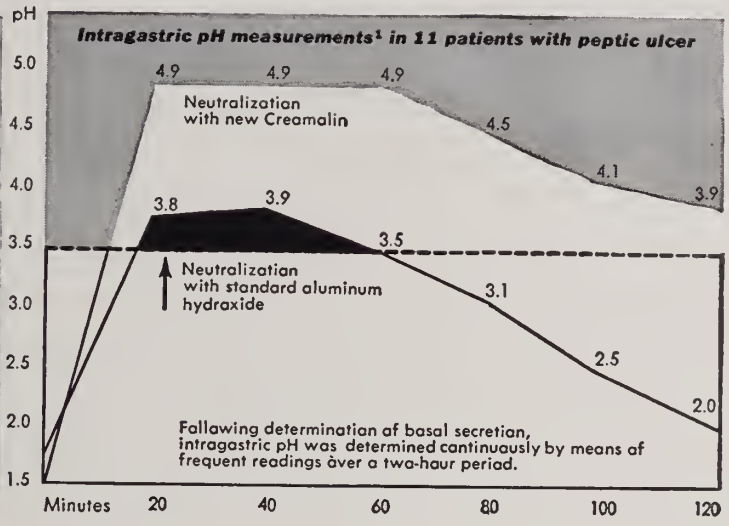
The format of the material is strikingly simple, attractively presentable for reading, on a fine quality of readable news print that has few typographical errors. One section, however, leaves one with the impression that two subjects have been confused and amalgamated into one heading—Chapter 31 dealing

(Continued on Page 316)

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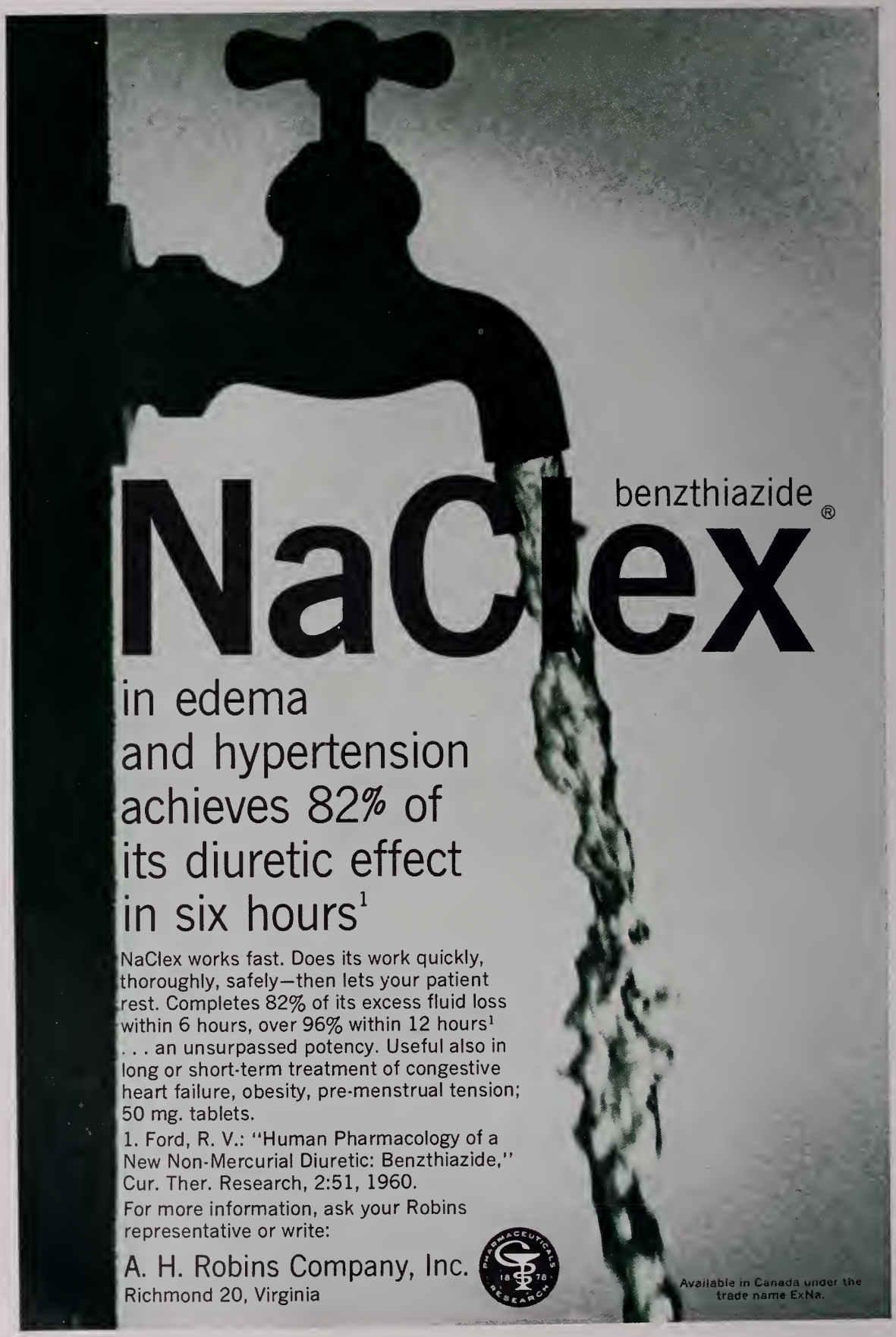
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References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.



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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE No. 82—The patient, a 42-year-old married, white, gravida 12, para 8, ab 3, consulted her physician in the third month of pregnancy. The subsequent prenatal course was normal.

The onset of labor was spontaneous and the patient was admitted to the hospital at 6:15 a.m., May 16, 1960. On examination, the presenting part was found to be high and the cervix thick, soft and dilated to three centimeters. Contractions were occurring at seven or eight minute intervals. The membranes were bulging at 9 a.m. and she was delivered at 9:53 a.m.

Bleeding Occurs

Immediately following the delivery, a large amount of bleeding occurred. A liter infusion of 5% glucose in water was started in the delivery room and the bleeding seemed to be controlled. It was not recorded that oxytocics were administered.

The patient was returned to her room. Within a few minutes she began bleeding very profusely and was taken back to the delivery room where another 500 cc of 5% glucose in water and 500 cc of whole blood were administered. The vagina was packed and the patient was given 1/6 grain of morphine. No mention was made of examination of the cervix for possible lacerations.

At 10:30 a.m. she was seen by a consultant; a cut down was done and more blood was begun. She was taken to the operating room at 11:10 a.m. for a hysterectomy. Under sodium pentothal anesthesia the abdomen was opened and found to be full of blood in addition to a hematoma infiltrating one of the broad ligaments. The uterus was removed and the bleeding seemed to be controlled. She received a total of five pints of blood under pressure during the operation.

During the closure of the fascia, her pulse became imperceptible to the anesthetist and closed cardiac massage was begun, Digitalis and cortisone were also administered. In spite of all these measures, she expired at 11:54 a.m. on May 16, 1960. There was no autopsy.

The cause of death was listed as: 1. Rupture of the uterus following spontaneous delivery. 2. Old scar in uterus. 3. Hysterectomy.

Comments

The committee believed that the information provided indicated the correct cause of death.

Several preventable features were present in this obstetric death. Blood should have been available when this grand multipara was admitted to the hospital. From the information supplied, it appeared that the profuse bleeding was not vigorously combated from its onset.

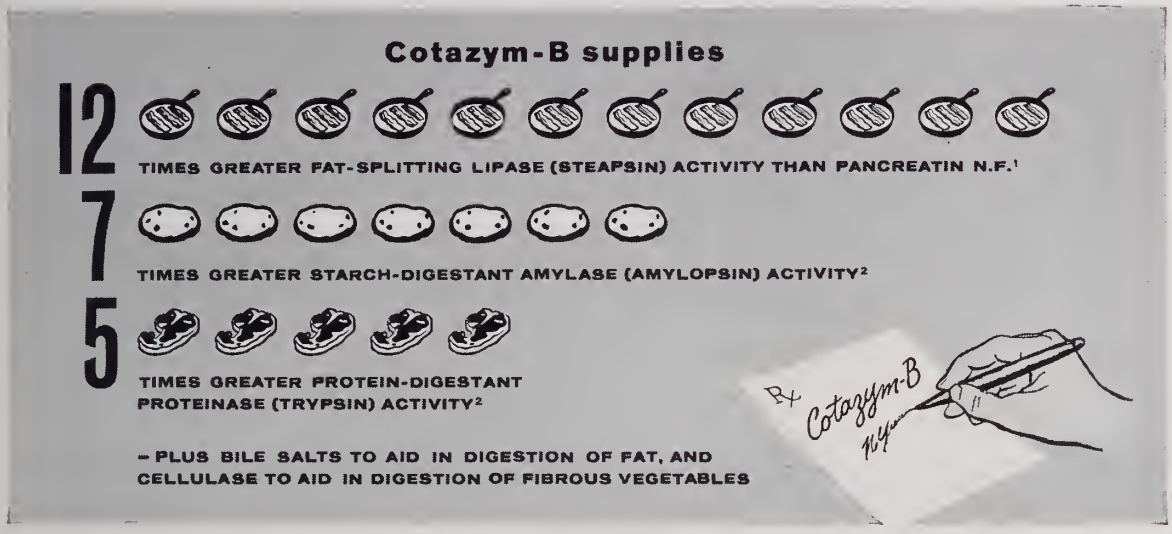
A Pitocin infusion should have been started when the bleeding was first noted. Actually, it should have been started to avert the possibility of the postpartum hemorrhage due to uterine atony which is so often encountered in the grand multipara.

Wise Decision Made

In the face of continued uncontrolled vaginal bleeding, the abdominal exploration for the determination of its source was a wise decision and it was not unnecessarily delayed. In the absence of autopsy findings, the committee suggested several possible reasons for the cardiac arrest. Insufficient oxygenation or use of too light a plane of anesthesia were possibilities. The patient could also have experienced unrecognized intra-abdominal hemorrhage resulting in exsanguination.

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Dosage: 1 or 2 tablets with water just before each meal.

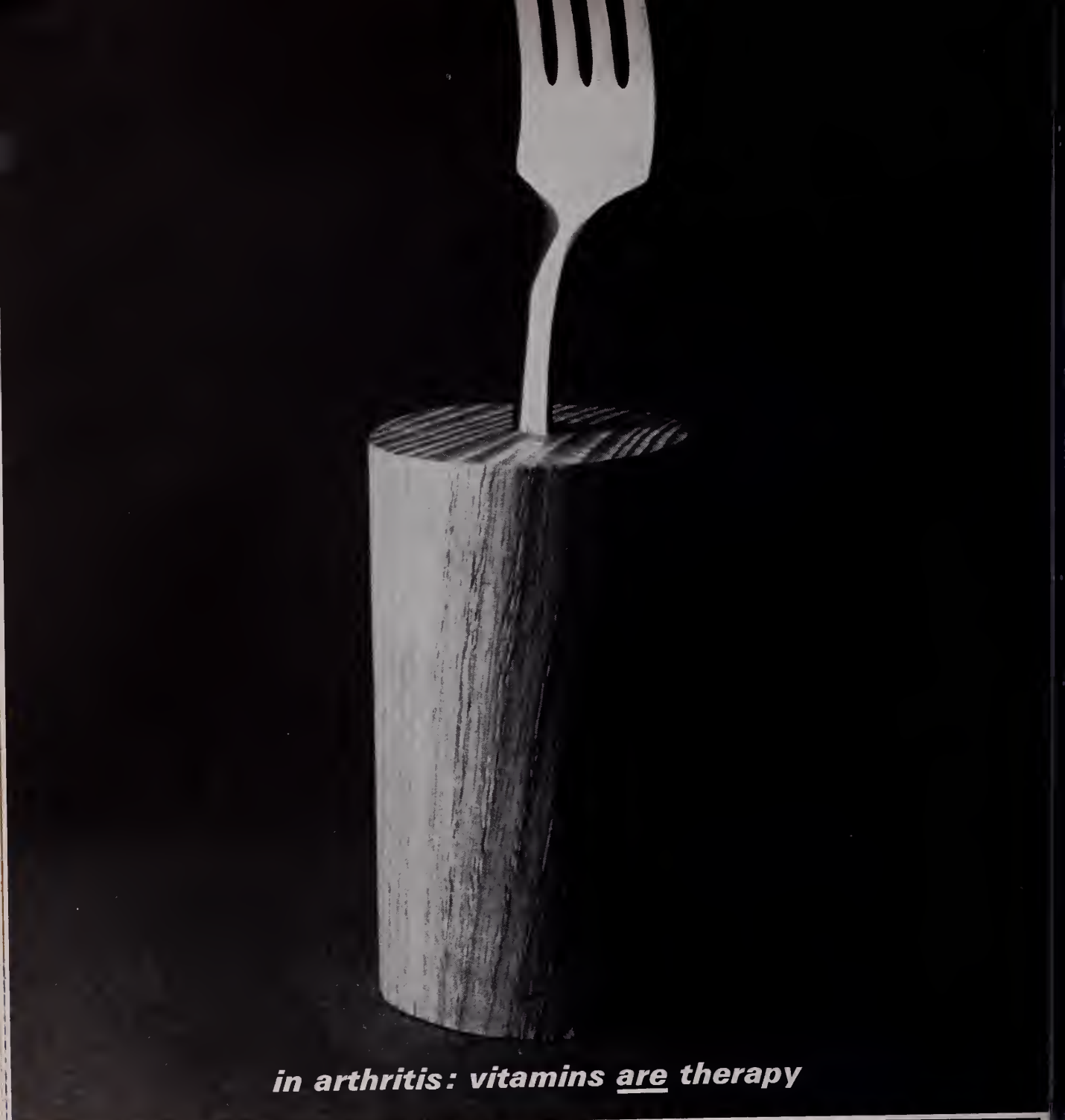
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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Welnstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

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PUBLIC HEALTH PAGE

Kentucky's State Occupational Health Program

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE only unit within State government having as its primary interest the health of the family breadwinner is the Division of Occupational Health, Kentucky State Department of Health.

This Division views the health of the worker as it is influenced by the demands of the job and the environmental setting in which it is performed. The incidental beneficiary of this attention is the employer.

The health status and fitness of individual workers must be carried out through in-plant health maintenance programs initiated by the employer or by the worker himself. Physicians and nurses in industry occupy a central position along with management in seeing that in-plant health services are provided as needed. A good framework for in-plant programs is outlined in the 1960 statement of the Council of Occupational Health of the American Medical Association, titled "Scope, Objectives and Functions of Occupational Health Programs."

The consulting nurse and medical consultant to the Division concern themselves with obtaining for the worker the benefits of good in-plant health programs as outlined by the AMA through the presentation of justifications based on common sense and demonstrated values. These consultants also serve to channel and help establish communications between management, plant nurses and physicians on one hand, and county health department personnel on the other. County health department programs may thus reach an important segment of the community.

It is essential, in such a well-defined area of practice, to know those things which can and should be done to protect a worker's health. A physical and a mental assessment are often needed to ascertain the worker's limitations as related to the stress demands of the job. Assessment and control of the environment is also necessary as well as health maintenance services of the plant physician, the industrial nurse or the first-aider, as required.

The Occupational Health Division, the county health department and the private physician may be looked upon as aids in the development and operation of these health programs.

The industrial physician and nurse and a trained group of scientists in the Division are provided with the latest knowledge and equipment to help assess environmental factors related to the health of the worker. Consultation in toxicology is available through the Division from the University of Kentucky Medical School.

The effectiveness of these aids reaches its highest level when communications between the Division

This article was prepared by Norman E. Schell, director of the Division of Occupational Health, Kentucky State Department of Health, Frankfort.

REPORT OF OCCUPATIONAL DISEASE

WORKER

Name—Please Print _____ Age _____ Sex _____

Address _____

Job or Actual Work Done: _____

EMPLOYER

Name—Please Print _____

Address _____

Type of Business (Work done or goods made): _____

(Over)

DIAGNOSIS

Nature of Disease: _____

Date of Onset: _____

Substances or Conditions Causing or Suspected of Causing Disease: _____

REMARKS: _____

Date: _____ Signed: _____, M.D.

Address: _____

Phone or Mail this report to your Local Health Department or to the KENTUCKY STATE DEPARTMENT OF HEALTH
Division of Occupational Health
275 East Main Street — Frankfort, Kentucky

Kentucky State Department of Health Form OH-6 (REV. 6-56)

Shown here are the front and reverse side of the card for reporting of occupational diseases. Cards are available to physicians from the Division of Occupational Health, State Health Department, Frankfort, Ky.

and management are such that essential information is freely shared. The reporting of occupational diseases by physicians will often provide the contact through which the need for services or information is ascertained. A card (shown on this page) is available from the Division of Occupational Health for this purpose.

The health problems of workers and the opportunity for effective public health work in employed groups have stimulated efforts within the Department of Health to strengthen this program which has shown marked growth in the last few years. Modern sicentific equipment has been obtained by the Division along with some increase in personnel. This program is expected to serve a most important role in public health as the economic development of Kentucky continues and with it the increasing health problems associated with industry.

C. A. Vance, M.D., Lexington, has been presented with a certificate of honorary membership in the Southern Medical Association. The certificate was presented to Dr. Vance in recognition of his continuous membership in the Association since 1913 and "because of the active support you have given the organization throughout these many years." **J. Duffy Hancock, M.D.,** Louisville, councillor for the State of Kentucky for the Association, made the presentation.

"Townsend Hospital" has been selected as the name for the proposed Pendleton County hospital. The name honors **William M. Townsend, M.D.,** Falmouth, who first proposed the hospital.

Drafting of Physicians Disrupts General Hospital Program

The resident physician training program at General Hospital, Louisville, has been seriously affected by the call to military service of six resident doctors, according to J. Murray Kinsman, M.D., dean of the University of Louisville Medical School, which staffs the hospital. Three residents in obstetrics and gynecology; one in anesthesia; one in radiology and one in internal medicine have either been drafted or called to active duty with their reserve units since July.

Besides interfering with the training program, the loss of the doctors has increased the work load on other physicians.

Doctor Kinsman pointed out that many teaching hospitals have been similarly affected and that the Association of American Medical Colleges is very concerned about the problem and planning to make an appeal to Washington. He said the situation could be alleviated if residents' military service could be deferred until they finish their training program.

NOTE

To County Society Secretaries and Members

Annual AMA dues will be increased $10 on January 1, 1962, and an additional $10 on January 1, 1963, following action by the AMA House of Delegates in New York, June 26. When this increase becomes effective, the annual dues for active members will be $35 a year in 1962 and $45 in 1963. This is the first AMA dues increase in 12 years.

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Q. Do the Blue Shield indemnity allowances fix the doctor's fee?

A. No. The fee charged by a doctor is a matter between him and the patient. Kentucky Blue Shield is an indemnity plan allowing up to specified amounts for procedures.

Q. Is there always a 12-month waiting period for pre-existing conditions under Blue Shield?

A. Yes, unless a special contract is written.

Q. Why should there be a waiting period for pre-existing conditions?

A. Rates are based on unknown, unpredictable illness. It would not be fair to enrolled members for Blue Shield to accept applicants who want to sign up only after a condition develops. Rates would soon be priced out of reach of everyone and there would be no reason to enroll until a condition develops.

Q. How can I tell what type of Blue Shield coverage the patient has?

A. By the code on the identification card. In a kit supplied to doctors' offices by Blue Shield there is a sheet which explains how to read an identification card. If for any reason you do not have a coding sheet, write to Blue Shield, 3101 Bardstown Road, Louisville 5, Ky.

Q. Will Kentucky Blue Shield cooperate with the proposed program of the aged suggested by the American Medical Association through the National Association of Blue Shield Plans?

A. This decision will have to be made by the Kentucky State Medical Association and then the Board of Directors of the Kentucky Physicians Mutual.

Q. What is a Professional Service Index?

A. It is an index which reflects the relationship of one procedure to another. It was developed by a committee of doctors appointed by the Chairman of the Board of the National Association of Blue Shield Plans and will be used for all national accounts.

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In the Books

(Continued from Page 302)

with fat embolism in its relation to anesthesia and with special reference to ether convulsions. These two syndromes are about as far apart in their etiology as one could imagine. The index contains all of the material in sub-categorized headings and also in cross headings under each alphabetical area. The binding of the book is of good quality and very pleasantly decorated as far as scientific publication is concerned. This book would be of interest to all anesthesiologists; to all physicians, particularly general surgeons and certainly to any intern, resident or person who has been in practice for a considerable number of years and has not kept up on his current Journals and other scientific literature.

This very pleasant presentation of Appraisal of Current Concepts in Anesthesiology would be an outstanding contribution to any physician, hospital or medical school library.

Robert W. Lykins, M.D.

New Members Added by KSMA

The following are new members of the Kentucky State Medical Association:

Edwin Koch, M.D., Louisville;
Richard McPherson, M.D., Louisville;
Anne D. Rickman, M.D., Louisville;
D. E. Wood, M.D., Russellville;
S. O. Hodges, M.D., Lexington.

Ky. Psychiatrists To Meet

The Kentucky Psychiatric Association will hold its spring meeting and election of officers at the Holiday Inn, Lexington, April 25. There will be a social hour beginning at 6:30 p.m. to be followed by a dinner meeting at 7:30 p.m.

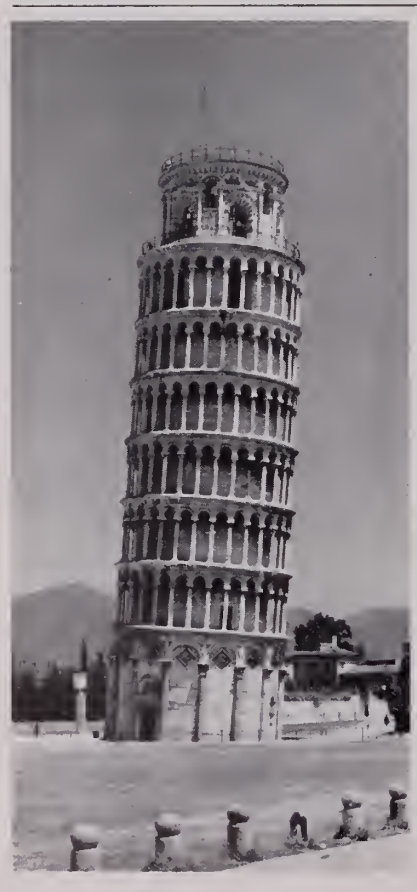
Guest speaker at the dinner meeting will be Walter Barton, M.D., Boston, Mass., president of the American Psychiatric Association and superintendent of the Boston State Hospital.

Industrial Medical Group To Meet

E. A. Irvin, M.D., medical director of the Ford Motor Company, Detroit, Mich., will address the dinner session of the third annual meeting of the Kentucky Industrial Medical Association March 15 at the Holiday Inn on U. S. 42, Louisville.

The meeting will begin at 2 P.M. The scientific program will include discussions of the following subjects: "Industrial Psychological Problems," "Industrial Injuries to the Hand" and "Industrial Eye Injuries."

Michael M. Hall, M.D., Campbellsville, was named "Campbellsville Citizen of the Year for 1961" by the chamber of commerce of that town. Doctor Hall recently completed a four-year term as mayor. He has practiced medicine at Campbellsville since 1933, except for a tour of duty with the U.S. Army Medical Corps during World War II.



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1. *Methyl-Testerone-Thyroid in the Treatment of Impotence,* A. S. Titeff *(Prepub. Report).*
2. *Thyroid-Androgen Relations,* L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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Doctor Teague Present as Combs Signs Kentucky-AEC Pact

At a signing ceremony February 8 in the headquarters of the Atomic Energy Commission, in Washington, D. C., Governor Bert Combs of Kentucky and AEC Chairman Glen Seaborg made Kentucky the first state in the Union to take control of most nuclear activities within its borders. Governor Combs said he expects the program will advance opportunities in the state in medicine, agriculture and industry.

Russell E. Teague, M.D., commissioner of health, was in Washington along with other members of the Governor's staff and Kentucky's congressional delegation, to witness the signing of the AEC federal-state agreement.

The Department of Public Health, headed by Commissioner Teague, will have charge of the regulation of licensing of radioactive materials when the agreement takes effect on March 26.

Representatives of the AEC, Council of State Governments and the U. S. Public Health Service were also present at the ceremony.

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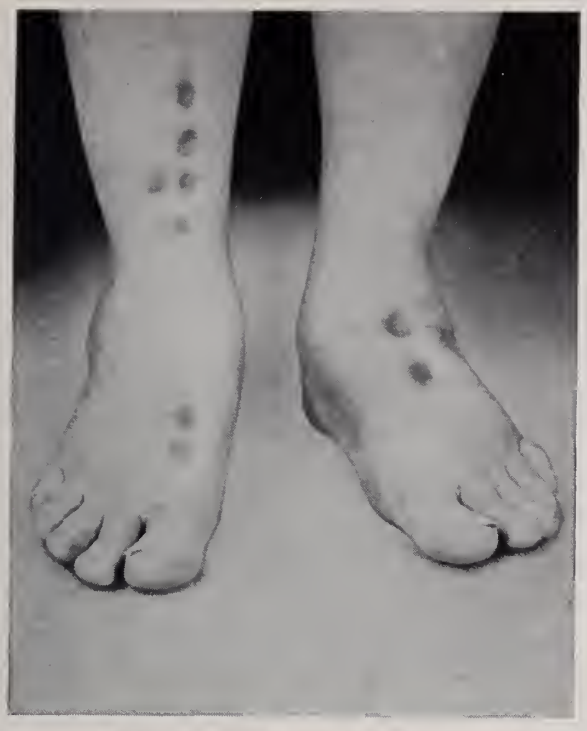
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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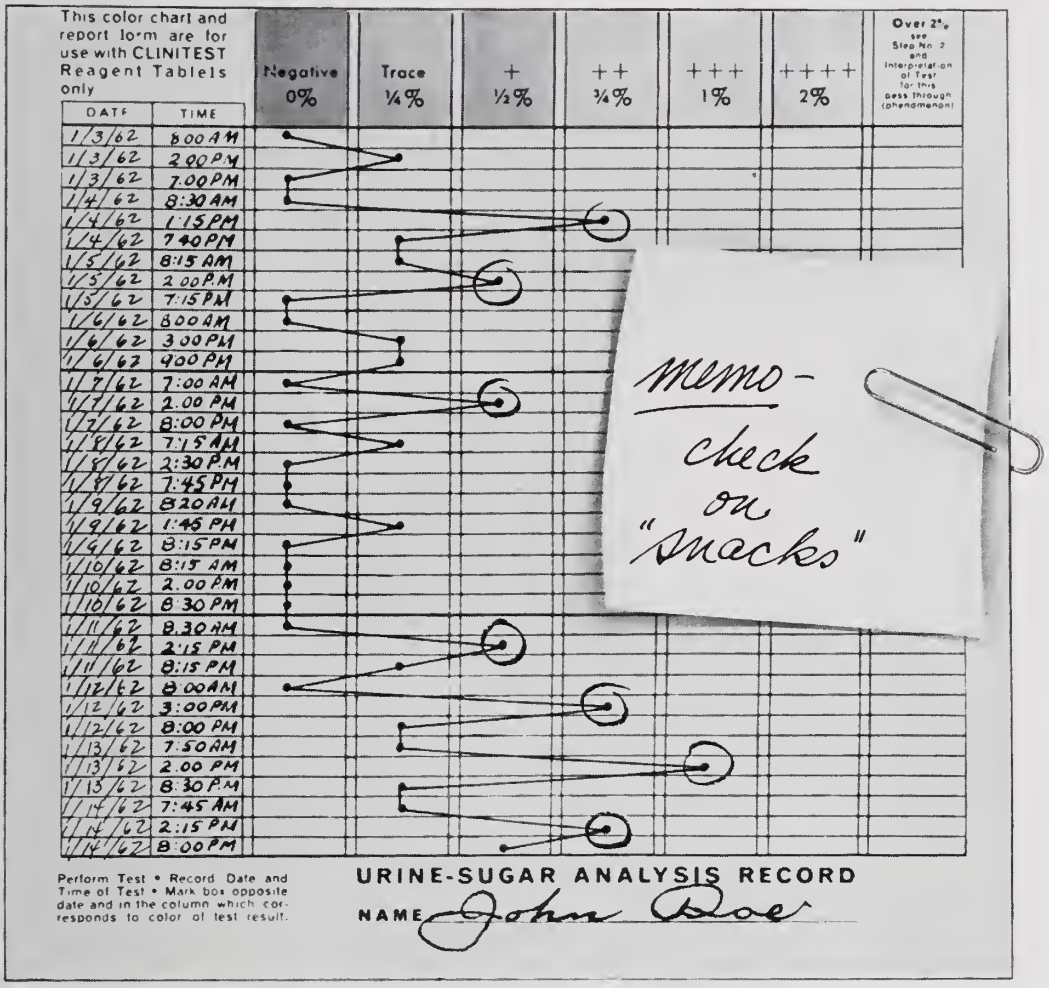
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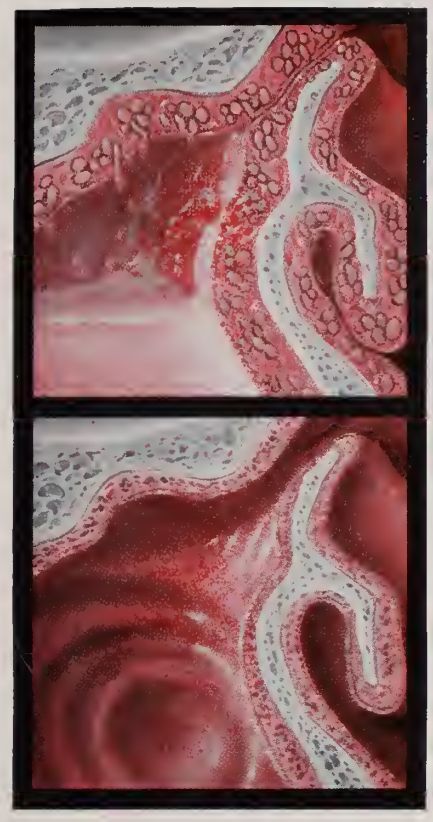
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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MESSAGE FROM THE PRESIDENT

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"Bad officials are elected by good citizens who stay at home on election day." Thus, paraphrased, goes an old and familiar saying.

We believe that physicians, as a group, are good citizens—that their interests and actions and dedication to the service of their patients, both individually and as a group, testify to their good citizenship. By the same token, we do not wish to imply that physicians fail to exercise their rights and privileges at the polls.

But, in 1962, good citizenship means more than just a periodic visit to the voting booth. The medical profession is in politics—the politicians have put us there! It is incumbent upon us, as individuals, to keep informed on political issues, to express our views and to support those candidates who share our views on these important matters.

To serve these purposes, the American Medical Political Action Committee (AMPAC) was formed. Its Kentucky component, the Kentucky Educational Medical Political Action Committee (KEMPAC), has also been organized and is now functioning. Every physician in Kentucky has received at least one mailing in regard to KEMPAC, with an invitation to join. Yet, hardly a day has passed during the last month that a fellow physician has not stopped the writer to inquire as to the meaning of the AMPAC lapel button he wore.

KEMPAC basically has but two purposes: To keep physicians posted on political and legislative matters and to support candidates whose views are consistent with the American way of life. It is completely non-partisan in its activities. Because its purpose is political, the organization of KEMPAC is entirely separate from KSMA.

KEMPAC deserves your support!

Henry B. Asman, M.D.
Vice President (Central)

**This is the first of three guest articles to be written at the invitation of Gaithel L. Simpson, M.D., president of the Kentucky State Medical Association. Pages will be written also by the other two KSMA vice presidents.*

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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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[1]Sollmann's Manual of Pharmacology, 8th ed., 1957, p. 507.
[2]Modern Drug Encyclopedia, 7th ed., 1958, p. 757.

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THE INSURANCE PAGE



Accentuate the Positive!

AT THE time this article is being written, the physicians of this country are actively engaged in a campaign of opposition to H.R. 4222. Most of us have written letters to our legislators expressing our reasons for such opposition. Many of us have been appearing before luncheon clubs, parent-teacher associations and other organizations to explain why we believe that the payment of medical expenses for our aged through the Social Security mechanism is not a desirable solution to the problem.

Merely to point out the objectionable features of the King-Anderson Bill is not adequate. Even labelling it as "socialized medicine" (which we know it to be) will not alter the desire of many of our old people to see this legislation enacted.

The problem of payment for health care is a very real one for a large proportion of our Senior Citizens. Advocates of the Social Security approach to this problem have told us, repeatedly, that we oppose their program, but that we have failed to offer a satisfactory substitute for it.

Must Show Better Way

If we are to succeed in "selling" our viewpoint to the public (and this we shall have to do if we expect to influence the votes of our legislators) we must be prepared to show that there is a better way than that being sponsored by the Administration to provide health care for the aged.

We should emphasize the fact that medical care for the low income group is available in most states through the Kerr-Mills program, or through similar medical assistance programs. We should not be reticent in pointing out that the physicians of our nation each year donate more than $600,000,000 worth of free medical care to those who are unable to pay for these services and that we have done this most willingly.

More Than Half Protected

We should point out that more than half of those over 65 already have some degree of financial protection against the costs of illness through voluntary prepayment coverage.

Within the next few weeks, in all probability, most, if not all, of our state medical associations will have endorsed the new nationwide uniform Blue Shield Plan for Senior Citizens, which has been approved by the American Medical Association. An intensive national program of education and publicity is to be undertaken in the near future to acquaint the public with the availability and the advantages of this voluntary plan.

The proponents of the Social Security approach to the health care of the aged will continue to assert that only through their system can adequate care for all be assured.

With this thesis we can now, even more than before, take issue since we believe that we can offer our aged a *better* system of coverage on a *voluntary* basis.

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2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—The American Medical Association said that President Kennedy misstated the real issue when he renewed his request to Congress for legislation that would provide limited health care for the aged under Social Security.

"We believe the American people are entitled to know that the real issue is not medical care versus no medical care for the elderly," Leonard W. Larson, M.D., president of the AMA, said.

Should Taxes Increase?

"The real issue is: Should wage earners and employers be forced to pay a substantial increase in taxes to provide medical care for millions financially able to take care of themselves?

"No one supporting this proposal has yet presented any evidence that such radical legislation is needed.

"The medical profession is for the Kerr-Mills law to help the aged who need help. We are for voluntary enterprise, including health insurance and prepayment plans for the non-needy aged."

Doctor Larson also disputed other statements on the issue which President Kennedy made in a new health message to Congress. Doctor Larson said that contrary to what Mr. Kennedy said, the Administration legislation (the King-Anderson bill) could interfere with the patient's freedom of choice of hospital and physician.

It would give the federal government "such broad power to control the practice of medicine in the nation's hospitals that the Secretary of Health, Education and Welfare would literally become the czar of American medicine," Doctor Larson said.

Doctor Larson also pointed out that it would not be a health insurance program, as President Kennedy said. Instead, it was "political medicine," Doctor Larson said.

"As the Supreme Court of the United States has ruled, Social Security is strictly a tax program with current taxes used principally to provide benefits for those now retired," Doctor Larson said.

The President's Messsage

President Kennedy's new health message was a summation of various Administration proposals in the field with some additions. It included:

—Federal aid for construction of medical schools and scholarships for medical students.

—Expanded health research, including a new institute for child health and human development.

—More funds for the National Institute of Mental Research.

—Federal loans to help set up group practice clinics.

—Encouragement of states to provide medical services for migrant workers.

—Federal research and grants to help combat air pollution in cities.

—A three-year program of federal assistance to get American children vaccinated against polio, diphtheria, whooping cough and tetanus. The government would pay the cost of vaccines for all children under five, provided state and local communities set up inoculation programs.

—Establishment of a National Environmental Health Center "to provide a focal point for nationwide activities in the control of air pollution, water pollution, radiation hazards and occupational hazards."

* * * * * *

To Study Cold Remedies

A broad investigation of cold remedies to determine whether their advertising overstates their effectiveness has been started by the Federal Trade Commission.

As a start, the Commission sent questionnaires to 24 major manufacturers of cold remedies. Answers to the questionnaires are mandatory under the Federal Trade Commission Act. When and how many additional manufacturers will receive similar questionnaires has not yet been determined.

The answers to the questionnaires will enable the Commission to make a comprehensive review of problems throughout the entire field and will assist in evaluating scientific evidence claimed for the medicinal preparations.

The survey seeks information on all such preparations offered for the relief or treatment of congestion, irritation, inflammation, infection, allergy or other conditions involving any part of (1) head, including the accessory nasal sinuses, (2) throat, (3) bronchiti, (4) chest, or other portions of the respiratory system.

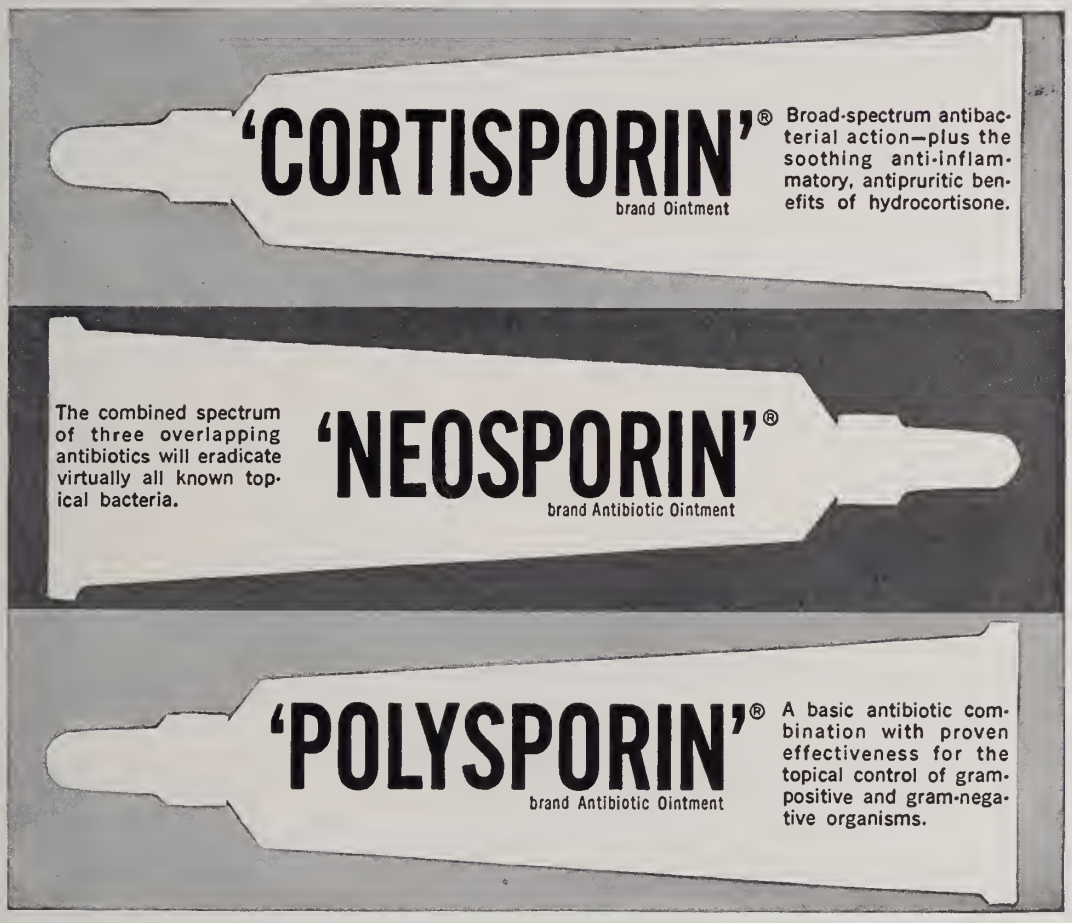
Will Investigate Claims

The questionnaires also seek information on claims for the relief or treatment of any symptom or manifestation of these ailments.

The Commission's resolution stated that it had reason to believe that certain corporations in offering such products to the public "may have falsely advertised and misrepresented" their efficacy. The resolution added that the public interest required that an investigation be conducted to determine whether such advertising was in violation of the Federal Trade Commission Act.

The names of the 24 manufacturers to whom the questionnaires were sent will not be disclosed, an FTC spokesman said.

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(Beck and Rosenthal, State University of New York)[3]



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(Titus, Pittsburgh)[5]

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1. Ranney, Brooks *South Dakota J. Med. & Pharm.* 11:479, Dec., 1958
2. Posner, L. B.; Fielding, W. L., and Posner, A. C. *Obst. & Gynec.* 2:81, July, 1953.
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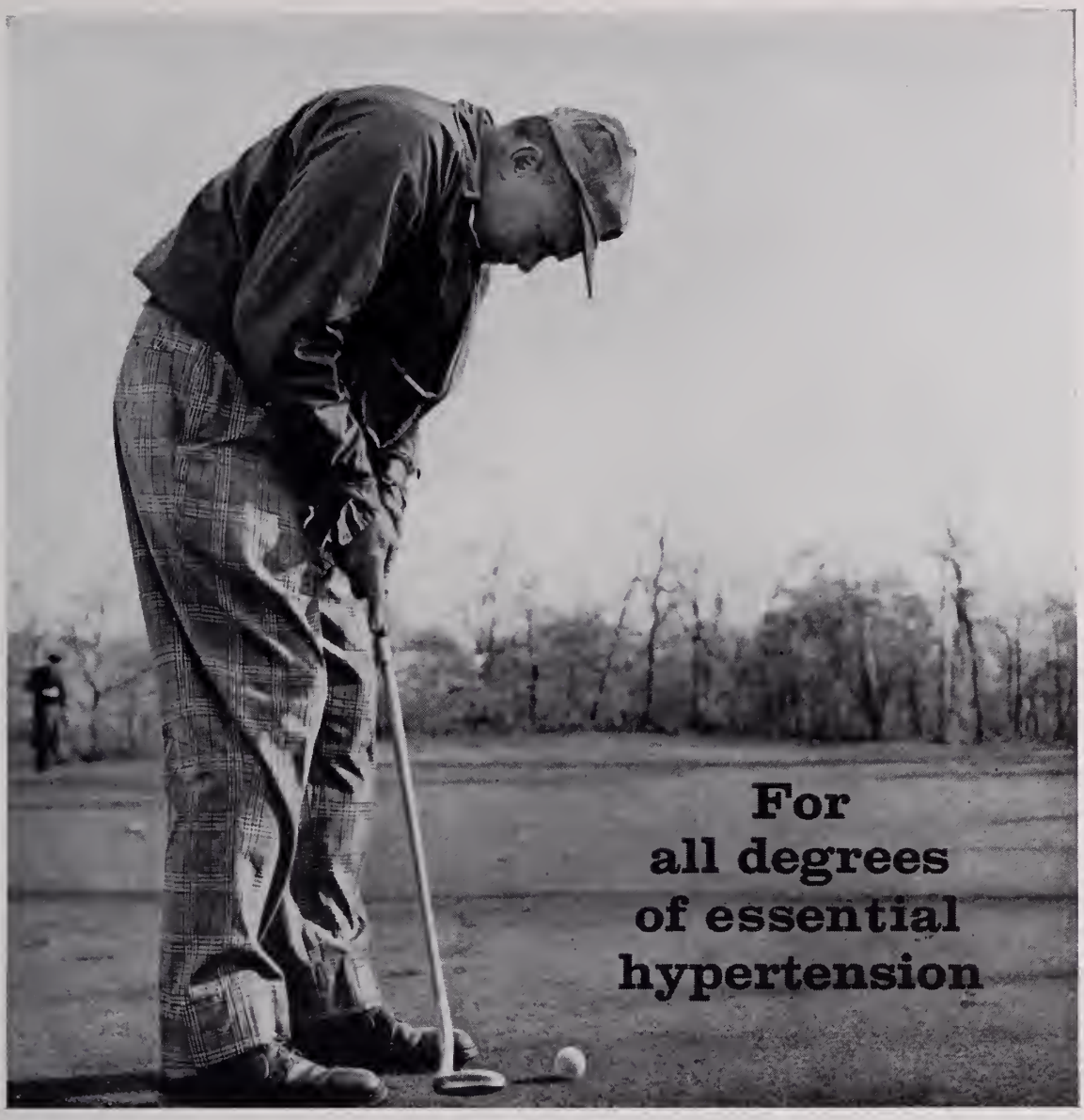
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†Hutchison J. C.: Current Therap. Res. 2:487 (Oct.) 1960.

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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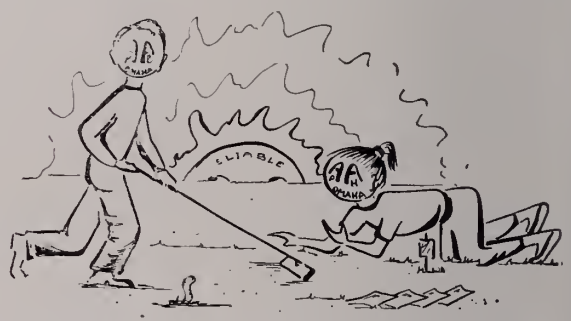
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*Schaefer, L. E.: Clin. Med. 8:1343, 1961.

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The JOURNAL of the
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Issued Monthly Under the Direction of the Council

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Basic Methods Used by the Internist in the Diagnosis of Diseases of the Chest*

Virgil A. Plessinger, M.D.
Cincinnati, Ohio

A careful history, thorough physical examination and laboratory tests are essential in diagnosis of diseases of the chest. The physician should be a well trained internist.

THE physician who makes a specialty of taking care of patients with diseases of the chest should be a well-trained, experienced Internist. Primary reliance is placed on the information obtained from routine blood counts and urinalysis, examinations of the sputum, other special laboratory tests, fluoroscopic and x-ray examinations of the chest, bronchoscopic and bronchographic examinations, a study of the patient's electrocardiogram and, where indicated, special tests of pulmonary function.

History Taking

The history as given by the patient must be augmented by asking for other details that do not seem to be important to the patient or for some other reason may not be volunteered. The physician must learn through experience how much reliance to place on the history as it is obtained and how to recognize the important, helpful bits of information while discarding the irrelevant. Each symptom should be subjected to detailed analysis.

In the case of thoracic pain, one should determine whether it is of specific enough character to determine if it is due to pleural involvement; whether it is of lancinating, electric shock-like character to suggest intercostal neuritis; whether it seems to arise from muscles of the neck, shoulders or chest; whether it is well localized over a costochrondral junction and associated with movements, palpation and activities known to aggravate such pain; whether it has characteristics associated with disturbances of the stomach, esophagus, pericardium and other mediastinal structures; whether it is of vague character and may be thoracic visceral pain referred to the thoracic wall, or whether it has characteristics suggestive of angina pectoris. If the pain can be attributed to pleural involvement, its association with other evidences of acute or prolonged illness or with other conditions may help in arriving at an etiologic diagnosis.

Such symptoms as cough and expectoration deserve careful analysis. What is the character of the cough? How long has it been present? Has it changed recently in severity or character? Is it productive of sputum? If so, how much and what is the character of the sputum? Is there occupational exposure to irritating fumes or dust? Does it occur in paroxysms? Is it associated with wheezing? What time of the day or night is it most likely to occur? Answers to these questions may help to determine if the

*Presented at the Annual Meeting of the Kentucky State Medical Association, September 19, 1961.

patient has a smoker's cough, acute or chronic bronchitis, bronchiectasis, lung abscess, tuberculosis, bronchial asthma or bronchogenic carcinoma. The diagnosis will not be made from such information, but it may guide one toward a correct diagnosis.

Hemoptysis is a symptom to be taken very seriously. This may occur in such mild conditions as acute upper respiratory tract infections or during the course of acute pneumonia, but at least half these patients will be found to have some disease such as tuberculosis, bronchiectasis, carcinoma, mitral stenosis or some other such serious condition. This manifestation of chest disease calls for thorough study to detect, if possible, its cause.

Dyspnea symptom frequently brings a patient to the physician for help. It may be difficult to determine whether it is due to cardiac disease or pulmonary disease. If associated with angina pectoris, edema of the ankles, or if it occurs in paroxysms at night, resulting in orthopnea, it is likely to be due to disease of the heart. Bronchial asthma, however, may be manifested by paroxysmal nocturnal dyspnea, cough and wheezing. Sudden acute dyspnea associated with chest pain may be due to spontaneous pneumothorax. The past history or the occupational history may disclose some long-standing condition that would lead to the development of pulmonary emphysema. An occupational history should cover all the years of the individual's engagement in occupations and should include in as good detail as possible just what the duties have been and under what environmental conditions the work was done.

The family history of such diseases as tuberculosis, diabetes, arthritis, cancer, asthma or other conditions may give valuable guidance toward a diagnosis. The history of contacts with individuals or animals having contagious or infectious diseases might be helpful.

Physical Examination

A complete physical examination must be done, not just an examination of the heart and lungs. Numerous diseases that have their origin outside the lungs have pulmonary manifestations or may have effects on the heart so that one cannot evaluate properly the thoracic manifestations in a patient without a thorough knowledge of the patient's general state of health and general physical findings.

One may observe hoarseness or stridor that might be a valuable clue in a diagnosis. Venous congestion of the neck and face may be observed indicating possible superior vena caval obstruction. Obvious wheezing may be noted. Evidences of psychic disturbance may be detected. Pallor, cyanosis, stained fingers from excessive smoking, pulmonary osteoarthropathy or cutaneous spider angiomata may be noted.

A careful search for abnormal lymph nodes must be made. An attempt to palpate the cardiac apex beat or a cardiac thrill should be made. The abdomen should be examined carefully for enlargement of the spleen, liver or kidneys, and for the presence of hernias. The testicles and prostate should be examined carefully in the male and a pelvic examination should be done in females because disease of these structures may help to determine the nature of an obscure abnormality.

It goes without saying that a careful thorough examination of the heart and lungs should be done, using inspection, palpation, percussion and auscultation, including the listening for rales after cough. This should be supplemented whenever possible by fluoroscopic examination of the chest.

Special Studies

Bronchoscopy and bronchograms frequently are necessary to help establish a diagnosis. Material for biopsy may be obtained and material for cultural studies, animal inoculation and cytologic study can be obtained. An endobronchial lesion might be found to account for an otherwise unexplained positive sputum for tuberculosis, or the source of hemoptysis may be found. Brisk hemorrhage sometimes is a contraindication to bronchoscopy but aneurysm of the aorta is about the only nearly absolute contraindication to the bronchoscopy.

Laboratory studies are necessary quite frequently as an aid to diagnosis. The routine blood studies may reveal anemia, polycythemia or eosinophilia that might help explain some abnormal condition of the heart or lungs. Urinalysis may reveal the presence of diabetes or serious renal disease that might have a close relationship to some disease of the chest.

Sputum examination is very important and good specimens must be obtained. Gastric lavage, tracheal lavage, bronchoscopic lavage or laryngeal swabs may be necessary to obtain material to be subjected to direct smear examination, concentration methods, cultures, animal inoculations and cytologic examination. A

Gram stain, as well as a culture, should be done on fresh sputum for the detection of pyogenic organisms. This may give an early guide as to the proper course of treatment. Acid-fast stains should be done. Special stains and cultures should be done for fungi. Inoculation of a mouse or a hamster may help isolate the Histoplasma capsulatum. Direct examinations of sputum on a slide should be done for Actinomyces, Blastomyces and Coccidioides immitis. Stained smears of the sputum should be examined for an excessive number of eosinophils if Loeffler's pneumonia is suspected. In the case of certain fungus diseases, place of residence, length of time living in certain localities and a history of travel in certain regions are important.

In the case of viral infections, the isolation of cold agglutinins or complement-fixing antibodies for psittacosis and ornithosis may be helpful. Complement fixation tests are helpful in the diagnosis of coccidioidomycosis and histoplasmosis.

Study of the electrocardiogram often is of great importance. It may help to establish evidence of right heart strain or enlargement in such diseases as silicosis, pulmonary emphysema, sarcoidosis and pulmonary fibrosis of various causes. It may help to determine whether the cardiovascular system will tolerate some necessary operation.

Biopsy of skin, muscle, endobronchial lesions, lymph nodes or the lung itself often is necessary before a definite diagnosis can be established.

Pulmonary function tests help to determine the degree of disability and, at times, the nature of the disability. By such means it may be determined whether a patient's complaint of dyspnea or limitation of exertion is justified, whether the dyspnea is due to some restrictive cause, a diffuse bronchial obstructive cause, or interference with the exchange of gases across the alveolo-capillary membrane. Such tests can help determine whether a patient can tolerate a contemplated operation on the lungs and how much each lung contributes to the over-all pulmonary function.

Summary

In summary, it can be seen we must rely on such basic methods as taking a careful history, doing a thorough physical examination, and complementing these with routine and special laboratory tests that seem indicated, and by such studies as pulmonary function determinations, bronchoscopy, bronchograms, biopsy and fluoroscopy. Of the utmost importance, careful and thorough x-ray studies have not been dealt with in this discussion.

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Practical Application Of Serum Protein Electrophoresis*

Edward J. Fadell, M.D.†

Louisville, Ky.

Serum protein electrophoretic fractionation affords definite diagnostic information in some clinical conditions. Significant individual component variations from the normal are helpful in prognosis in many instances.

THE methodology for serum protein electrophoresis as used in our laboratory is essentially that of Spinco Procedure B, as modified by Sunderman.[1] The separations are made at room temperature on S & S 2043A filter paper for a period of 18 hours with a direct current of 2.4 milliamps, using Barbital Buffer at pH 8.6. The strips are dried in an oven at 105°C. for 30 minutes. Staining is done for 20 minutes in a saturated solution of Amido Black 10B.

In a recent survey of laboratories, the determination of albumin by means of electrophoresis revealed a variability from 2 to 5 grams per cent. The variability in the concentrations of the globulin fractions was even greater. It was felt that a standardization of the procedure is necessary. Certainly Sunderman's recommendations as to methodology are readily applicable to the general hospital laboratory.

Total protein in our laboratory is chemically determined by the Wolfson-Cohen, Calvary and Ichiba method.[2] Twenty-eight per cent sodium sulfite is used to precipitate the globulins. This correlates better with electrophoresis than does 23% sodium sulfite as the precipitating agent in that no alpha 2 globulin is lost.

**Presented at 1961 Annual Meeting of Kentucky State Medical Association, Louisville, Ky., September 19-21, 1961.*

†Methodist Evangelical Hospital

Limitations and Illustrations

From a diagnostic standpoint there is a distinct limitation in the use of serum protein electrophoresis. Most disease states produce entirely nonspecific protein derangements. This is most apparent in the infectious states. In both acute and chronic infections there is a tendency to a decrease in the albumin concentration and an increase in the alpha 2 globulin.

Figure 1 demonstrates the pattern as seen in lupoid hepatitis, i.e. an instance of postnecrotic cirrhosis in a young female demonstrating a positive lupus erythematosus phenomenon (Kunkel girl)[3]. It is to be noted that the gamma globulin is greatly increased and heterogeneous, appearing as a broad hump. Although such a pattern is of interest, similar patterns are seen in a wide variety of abnormalities including sarcoid, collagen diseases and other forms of cirrhosis. However, in these conditions the elevation of gamma globulin is generally not as pronounced.

Figure 2 is typical of the pattern seen in approximately 75% of instances of multiple myel-

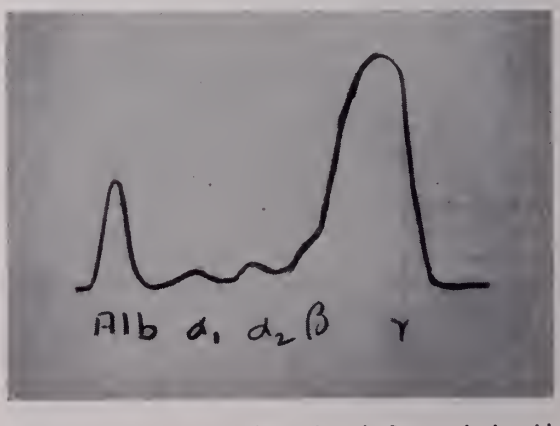


Figure 1. Serum Protein Electrophoresis Pattern in Lupoid Hepatitis.

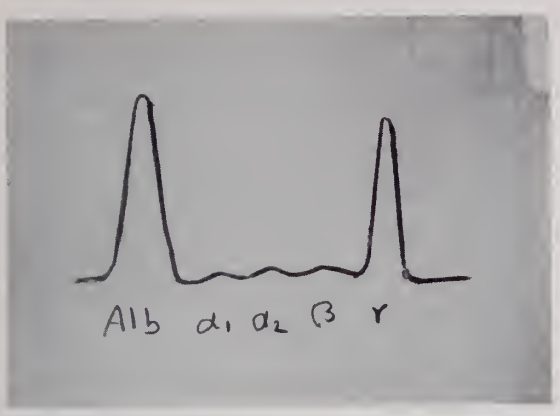


Figure 2. Serum Protein Electrophoresis Pattern in Multiple Myeloma.

oma. In these instances the abnormal proteins appear as a spike. In the interpretations of these homogeneous paraproteins, Kyle[4] has made the observation that utilization of the height to width ratio of the abnormal protein allows more precise interpretation of the abnormality. The height is measured from the baseline to the top of the abnormal protein component while the width is measured at the midpoint between the base and the top of the protein component. These measurements are recorded in millimeters. In 70% of instances of myeloma the height-width ratio ranged from 15-1 to 4-1. The ratio of 4-1 is the lowest diagnostically significant level. In the Figure, the abnormal protein migrates in the gamma globulin position. The M protein, although appearing most commonly in the gamma globulin region, may appear at other sites. A similar homogeneous peak may be seen in macroglobulinemia, necessitating ultracentrifugation for differentiation.

Figure 3 is typical of the pattern seen in the nephrotic syndrome. Here the presence of a marked depression of gamma globulin, together with albumin depression and a conspicuous alpha 2 globulin, is most suggestive of this condition. If the nephrotic syndrome is associated with albumin depression and a gamma globulin in a normal range, one may suspect that the nephrotic edema may be a manifestation of systemic lupus erythematosus.

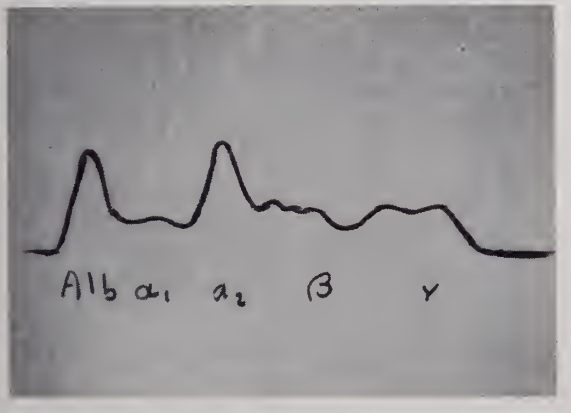


Figure 3. Serum Protein Electrophoresis Pattern in Nephrosis.

Electrophoretic separation of the proteins affords a ready diagnostic tool in suspected instances of gamma globulin deficiency (Fig. 4). This is true not only in congenital instances but also in acquired defects in gamma globulin synthesis such as that commonly seen in the lymphomata. It is to be emphasized that small depressions in gamma globulin are fairly common. In the interpretation of tracings references to hypogammaglobulinemia of small magnitude should not be confused with congenital or acquired gamma globulin deficiency in which the values characteristically are in the range of 0—100 mg. per 100 ml.[5] Gordon and Spencer[6] have suggested that hypogammaglobulinemia of a much smaller magnitude may be fairly common in children and different from the classic descriptions of congenital agammaglobulinemia. These children suffer from recurrent infections and all improve dramatically with small doses of gamma globulin. The exact significance of their observation is a matter for speculation.

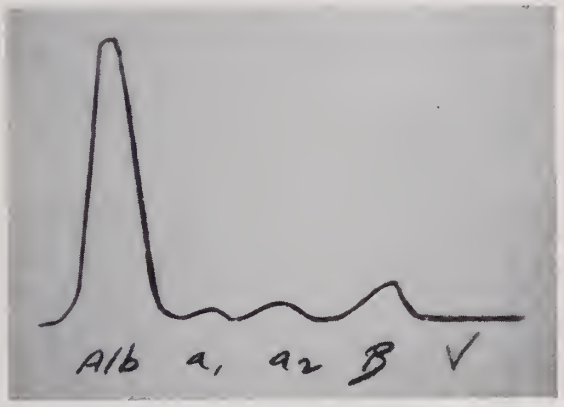


Figure 4. Serum Protein Electrophoresis Pattern in Agammaglobulinemia.

Summary

As noted by Ogryzlo, et al,[7] the greatest value in serum protein electrophoresis is the observation that sera having significant deviations from the normal have not, in general,

(Continued on Page 369)

Milker's Nodules: Presentation of Three Cases*

Ullin W. Leavell, Jr., M.D.
AND
H. Davis Chipps, M.D.
Lexington, Ky.

Milker's nodules are tumors that develop on the exposed areas of individuals who milk cows that have natural cowpox. Three cases are presented with clinical and microscopic features which are characteristic of the disease.

THREE cases of milker's nodule have been found in the State of Kentucky. It seems well to record this disorder as occurring in this State and to include it in the differential diagnosis of growths on exposed areas.

Milker's nodules are lesions that may occur on exposed areas of individuals who milk cows having natural cowpox. True cowpox produces vaccinia in man, while false or natural cowpox produces milker's nodules.

Description

In man, the lesion starts as a small red papule and gradually enlarges, over seven to ten days, to 1.5 to 2.0 cm. in diameter. It has a reddish-purple color and usually it involutes spontaneously in six to eight weeks. Figure 1 shows the nodule on the hand of a patient. Recent studies[1] of material from the lesions have shown virus-like corpuscles which are different from those of vaccinia. It was recognized as early as 1799 by Jenner[2] that cows may be infected either with true or false cowpox.

The disorder is manifested first as a small papule on the teats of cows (Figure 2). It may later become pustular and usually heals in about 2 weeks. Vaccination against smallpox does not prevent acquisition of milker's nodules, and persons with active milker's nodules can be successfully inoculated with smallpox vaccine.



Fig. 1. Nodule on dorsal aspect of hand of Case I.

Findlay and Haig[3] report successful infection of the chorioallantoic membrane of developing hens' eggs from a human nodule. Using infected membrane material, they were able to successfully inoculate a cow.

The pathology of the disease is suggestive but not diagnostic of the disorder. The most striking feature is fingerlike downward projections of the epidermis (Figure 3). There is a dense infiltrate consisting of lymphocytes, polymorphonuclear leukocytes, histiocytes and cosinophiles. Parakeratosis, acanthosis, pro-

Presented before the Kentucky Society of Pathologists at the 1961 Annual Meeting of the Kentucky State Medical Association.



Fig. 2. Papules on teats of cow owned by Case 1.

liferation of capillaries and vesicle formation are common findings.

Differential diagnosis includes granuloma pyogenicum, melanoma, verruca vulgaris and ecthyma contagiosum.

No treatment is necessary, as the lesion regresses, usually spontaneously, in from 6 to 8 weeks.

Case Reports

Case 1. A 35-year-old white male was seen because of a growth of 10 days duration on his right hand. It had grown several times larger than when first noticed, and had not been treated. He milked about 12 cows daily, six of which had warty growths or papules on the teats. He had no sheep.

Examination revealed an elevated purple tumor 1.0 cm. in diameter on the dorsal aspect of the right hand involving the web between the third and fourth fingers. The impression was milker's nodule and the lesion was excised for pathological examination. Microscopic study showed hyperkeratosis and acanthosis. The rete pegs were elongated. There was an intense infiltrate of lymphocytes and eosinophiles. There were many capillaries. The biopsy site healed uneventfully in 3 weeks.

Case 2. A 69-year-old white male was seen because of a growth of two weeks duration on the dorsal aspect of his right hand. The lesion had not changed in size, and had not been treated. He stated that he milked two cows daily and that their teats were "chapped."

Examination revealed a nodule on the dorsal aspect of his right third knuckle, 2.0 cm. in diameter. The impression was either epithelioma, milker's nodule or orf. Biopsy showed hyperkeratosis and parakeratosis. The dermal papillae were elongated and there was an intense infiltration of lymphocytes and plasma cells in the papillary layer, with occasional eosinophiles. The microscopic picture was compatible with milker's nodule. The biopsy site healed uneventfully.

Case 3. A 44-year-old white farmer was referred because of an untreated growth of three months duration on the left index finger. The lesion did not burn or sting; however, it itched a great deal. He milked a cow daily, but had no sheep. Examination revealed an elevated purple tumor on the left index finger, 1.5 cm. in diameter. The clinical impression was either milker's nodule or verruca.

Microscopic examination showed hyperplasia of the epidermis with edema and focal degeneration of squamous epithelium. There was an exudate of serum and neutrophiles on the surface and a central ulcer, with an intense infiltrate of lymphocytes and eosinophiles in the cutis. The changes were consistent with milker's nodule. The site was healed about three to four weeks after biopsy.

Conclusion

Milker's nodules are not uncommon in the State of Kentucky and should be considered in the differential diagnosis of growths on exposed areas of patient.

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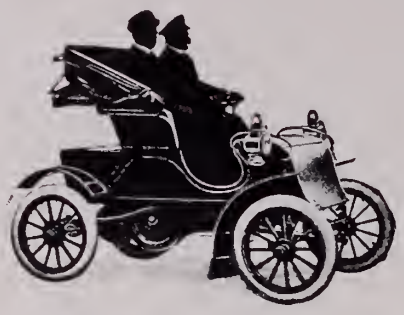
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Fig. 3. Fingerlike downward projections of epidermis with dense infiltrate in dermis.

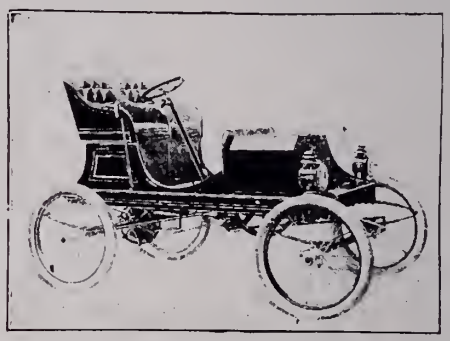


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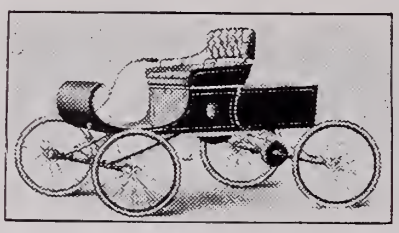




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"SOME THINGS THE OBSTETRICIAN MAY DO TO ASSIST THE LYING-IN WOMAN, AND SOME THINGS THAT HE HAD BETTER NOT DO."*

By T. J. Shoemaker, M.D.
Morganfield, Ky.

By way of explanation I would say I wrote the following paper just as I would write a letter to a friend. I did not refer to any authors of books, but wrote my thoughts down just as they came to me; thus you will understand why it is I seemingly jump, as it were, from one subject to another. I did not expect to advance any new ideas, but to call attention to some things that may have passed out of the mind of the busy practitioner.

It is not my intention to attempt to write a paper to teach how to attend to a case of obstetrics, but to mention some things that will be of advantage to the patient as well as the obstetrician.

When the obstetrician is called to attend a lying-in woman, he should enter the sickroom quietly, speak pleasantly to the patient, and ask her how she is feeling. If everything is going on quietly and smoothly, after he has paid his respects to those in attendance, he should call for water that has been boiled and not cooled with cold water; to this he should add his bi-chloride tablets and then bathe and wash his hands thoroughly, and if he has not previously pared his finger nails he should do so now, and get all of the dirt from under them. If he has whiskers he should also give them a bath and disinfect them. When he has everything aseptic he may walk gently up to the bed and ask the patient to permit him to examine her, that it is very proper that he should make the examination to ascertain her condition, that he will not cause her any extra pain.

The examination should be made in the most gentle manner with the index finger of the right hand, first lubricating it with pure fresh olive oil. A well educated index finger will make known many things to the accoucheur: whether the os uteri lies low or is high up, dilated or dilatable, whether in a normal position or turned back toward the hollow of the sacrum, and many other things.

If pains are severe and the os uteri is turned

**Read before the Kentucky State Medical Association, April 1903.*

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back they will never do any good until the accoucheur brings the os uteri down straight and holds it in position. This is not always so easily done.

Sometimes you may succeed in reaching the os with the index finger and sometimes you can not. Then one might try turning the patient on her left side and by pressing down on the top of the uterine tumor with the left hand, he may be able to reach the os with the index finger of the right hand. When he once gets it in the proper position he should hold it there until the pains have sufficiently dilated the os for labor to go on in a regular manner. Sometimes when the pains are slow and weak he may start them up by titillating the os in a circular manner; or when the os uteri is low enough one might stretch the os by using the index finger and its twin brother, and this will increase the pain as well as dilate the os. Sometimes we can increase the pains by pressing on the perineum with the index finger when the pain is on or when we want to bring on the pains.

Sometimes in a lifetime we may run across a crow quill os uteri, and we will about come to the conclusion that the woman's os has grown entirely up, and that it has been hermetically sealed up as it were, after the pregnancy has taken place. But do not despair, time and perseverance will help you out, and you will eventually find the little spot high up and far back that you can make some impression on with the end of the index finger. And when you once succeed in getting the end of the index finger into the os uteri, never take it out if you can possibly help it until you have brought it down and forward, and don't you ever let your finger forget its cunning. But do not be too officious when labor is progressing regularly, although we may hasten labor by titillating the os and thus increasing the pains.

It requires some judgment about giving chloroform in labor when those cutting, grinding pains are dilating the os. Sometimes a little whiff of chloroform will take off the rough places with the nervous lying-in woman just as a drink of good bourbon whiskey will make the stones and clods smaller when riding over a rough country road in a buggy. But you can not at all times keep up chloroform to an advantage. Sometimes it will stop the pain entirely and you will then be compelled to abandon it absolutely. There is one thing I would warn the young accoucheur against. When the case is a primipara and the pains are going on lovely and the os uteri is not only dilatable but dilated well, and the bag of water is well formed, and you feel like you are going to have a chance once more to be free and sit beside your best girl in the near future and pour into her ear tales of love; or if you are just married, that you will soon be by the side of your darling little wife, do not in your anxiety rupture the fetal membranes. If you should become so unguarded at an evil moment, you will have, I fear, many hours to regret it. The pains will stop suddenly, everything will come to a standstill; you will think about your past troubles, and your sins, and dead relations that were once so dear to you. You will think your past troubles were small compared with how you have just acted. Your fondest hopes have all departed and been blasted, and you are doomed to sit like a condemned criminal until nature may after a long time return to action for your relief. The accoucheur had better wait and permit the baby to be born with a veil over its face than to do such a rash thing. Let the bag of water help the labor as long as it will hold on. Of course when you have a multipara in labor, when the os is well dilated and the bag of water well formed, you may take advantage of a hard pain and rupture the membranes and labor will go on lovely. Even if it does not you can give a drachm of Squibbs fluid extract of ergot and repeat if necessary in a reasonable length of time. But I would not advise more than two doses of ergot for fear of harm to the child *in utero*. If that does not do the work, desist, and either wait a reasonable length of time, or put the patient under the influence of chloroform and deliver her of the child at once with the obstetrical forceps. I think it is a very good practice if the labor has been tedious to give, just before you deliver the placenta, a teaspoonful of fluid extract of ergot to the mother and see that the placenta and membranes are entire. Be careful to turn out all the blood clots from the womb and vagina. I think it is a good plan to keep up a strict watch over the patient after confinement for an hour after the child is born and to place the left hand over the womb and keep control of it, if you suspect that there is going to be any post partum flooding. You can always tell when that is going on. You will have less trouble than to let the womb get away from you and

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have to introduce the hand and arm up about the region of the stomach to bring away blood clots and induce the womb to contract even by holding a lump of ice in place in the body of the womb. After you have had a case of post partum flooding and have gotten the womb back to its proper size, next time you would be more than willing to hold it in the hollow of your hand for an hour. One never forgets a bad case of post partum flooding; that pallor of the face will haunt you for a long time thereafter.

I want to say something to you about support to the perineum, so called. When you have extra hard pains to contend with and the head of the child is advancing rapidly toward the perineum you don't want half a dozen of wiseacres standing around yelling to the lying-in woman to shut her mouth and put her chin down on her breast and bear down with the pains. The accoucheur wants to be master of the situation himself. Now it is the head that needs the holding back to regulate its pressure against the perineum; this the accoucheur can do with the index and its twin finger of the right hand when the pains are at their hardest, until the perineum is perfectly stretched. If you depend on supporting the perineum from the outside before it is properly stretched you may have the chagrin of feeling it divide beneath your hand. Of course after the perineum is properly stretched it is all right to support from the outside. I want to say something about the lying-in woman getting tired of and vexed at the accoucheur's meddlesome assistance. Perhaps many of us examine our patients too frequently, but some women are not satisfied if you are not around them examining them, etc., and they think you are not doing anything for them. But there are others who do not want it and they may say some ugly things to the accoucheur, or about him. Then he might quietly withdraw and let her alone if everything is going along all right and he can leave her safely. He may employ his time talking to the other ladies about the room, or pick up something and pretend to read; just any old thing will do, an almanac if you can not find anything better.

In a short while she will come around all right; you will hear her call for help, and if no one pays any special attention to her you will hear her cry out, "Oh! I am going to die!" Pretty soon if she does not call for you some one else will say, "Doctor, will you do something for the lady, please."

I want to say something to you about the use of chloroform in cases of labor. There are but two objections to its use so far as I know, if the patient can use chloroform at all, viz: it sometimes stops all pains and the obstetrician may have to abandon it altogether, and I think a long continued use of it in a case of labor may cause post partum flooding. I think in those cases it is best to give ergot hypodermatically before delivering the placenta, or if the stomach is not sick a drachm of fluid extract of ergot by the mouth. I always use Squibbs' chloroform for inhalation.

I want to say something to you about the delivering of the placenta, and that will close this paper. When I attended medical college they taught that the accoucheur should wait for a time, say an hour, after the child was born before delivering the placenta. For years I have always delivered the placenta as soon as I could remove the child. If the child is strong it is not necessary to wait until the pulsations have stopped entirely in the umbilical cord. I tie the cord and remove the child. Keep a strict watch over the uterus, and when the child is out of the way, make gentle pressure on the womb and slight traction on the cord and ask the patient to blow against the palm of the right hand. This procedure throws the diaphragm down and assists in bringing on the contraction of the uterus. The practice of the old mid-wife of having the patient to blow in a bottle will accomplish the same thing. I have never seen any good reason for waiting to deliver the placenta; on the contrary if you will follow up the contractions caused by labor you will succeed much better than if you wait and let the contractions die down; and then you are not so liable to have the so-called "hour glass contractions" of the womb. Labor pains make the same impressions on the uterus that electricity has on the muscles of the frog's leg, the contractions will continue after the cause is removed, and thus you will see the advantage of the quick removal of the placenta. If I am so unfortunate from any cause as to have a "bobtail" placenta I give the patient chloroform and introduce my hand and deliver the placenta without delay.

(From Volume 1 (1903) issues of The Journal (Bu'letin) of the Kentucky State Medical Association.)

RECENT INVESTIGATIONS CONCERNING THE ETIOLOGY OF SMALLPOX

The interest attaching to vaccination seems perennial. The results obtained hitherto seem rather to have confused the subject than to have thrown any especial light on it. Since we have learned the specific nature of so many disease processes, the nature of the process taking place in vaccination has been studied by both the bacteriologist and the zoologist, with the results as stated above. In one respect, at least, there appears to be a consensus of opinion, and that is that vaccinia is a modified form, or an incomplete form, of variola; and the recent studies of Dr. Councilman, of Harvard, and his assistants, seem not only to confirm this view but to offer at least a satisfactory working hypothesis by which further research may finally demonstrate the nucleus of truth.

The one striking thing in connection with Dr. Councilman's work is his use of the eruptions of variola and vaccinia in their earliest stages, before the eruptions become altered in any of their elements by secondary invaders. The changes wrought by these secondary invaders in other diseases frequently enough alter not only the clinical, but the histological picture, and, while the time element varies, it is always an important element, and seems to have been eliminated in these studies. At the recent meeting of the American Association of Pathologists and Bacteriologists held in Washington, May 12-14, 1903, Dr. Councilman demonstrated what he considers the specific micro-organism of vaccinia and variola. According to Dr. Councilman's opinion this organism is a protozoan and not a bacterium. It has a well defined cycle of existence, one phase taking place in the protoplasm of an epithelial, or tissue cell—the other being the completion of its sexual development and taking place in the nucleus of the cell.

In vaccination there is simply the asexual, or non-sexual, development of this organism in the *epithelial protoplasm;* and this type of the disease produces the immunity to variola. Variola comprises the full sexual development of the parasite whose manifestations are in the *nucleus* of the cell itself.

In the early stages at which these studies were made there is no invasion of leucocytes, and the objection of the French and German observers, that the organisms are simply forms of degenerated leucocytes, is without basis.

In these studies the present impossibility of cultivating protozoa outside of the animal body is as great a hiatus as with the parasites of malaria, and there are many other interesting questions in connection with them as yet unsolved. It must, nevertheless, be admitted that these observations are as keenly interesting as the theory they have given rise to is unique, and that the scientific world will await further knowledge with much interest.

J. A. FLEXNER

(Communication to The Kentucky State Medical Association Bulletin—July 1903 Issue—Volume 1.)
(Doctor J. A. Flexner is the father of Morris Flexner, M.D., Louisville physician.)

(From Volume 1 (1903) issues of The Journal (Bulletin) of the Kentucky State Medical Association.)

* * * * * *

Serum Protein Electrophoresis

(Continued from Page 361)

been consistent with good health. As a definite diagnostic tool, the usefulness of the determination is limited to the M proteins, the hypogammaglobulinemias and the agammaglobulinemias. It is of some help in the nephrotic syndrome, especally if the possibility of systemic lupus is entertained.

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SPECIAL

DEDICATION SECTION

Page 373

This

Issue

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville Children's Hospital

Sublingual Hematoma: Unusual Complication of Hemophilia

Edwin P. Scott, M.D.,* and Marion F. Beard, M.D.†

SUBLINGUAL hematoma requiring tracheotomy is one of the complications of hemophilia. With all of the studies that have been done on hemophilia in recent years, and with the improved diagnostic and therapeutic facilities, only nine cases of this particular complication have been reported in the literature.[1-9] Because of the apparent rarity of this complication, it is deemed advisable to report this case. The lack of family history of hemophilia and the initial low prothrombin determinations add further interest to this case.

Baird[8] reported the first case of hemophilia in a child who was suffering from sublingual hemorrhages in which tracheotomy was necessary and in which recovery occurred.

Case Report

This child was admitted at the age of one year to the Children's Hospital, Louisville, Ky., on November 16, 1933, because of a laceration of his forehead which had been bleeding for 24 hours. The infant bled for three days from the cord at birth, and when the child was two months of age, the mother noted purpuric spots from the slightest trauma appeared on the skin. The General Hospital Clinic made a diagnosis of purpura when he was 10 months of age.

Family history, including three older siblings, was entirely negative for hemophilia and has since remained negative.

Physical examination on this admission revealed purpuric spots over the entire body with a very minute laceration of the forehead.

Laboratory studies revealed: 2,230,000 red blood cells per cu. mm.; 8,100 while blood cells; hemoglobin, 6.3 gm/100 cc blood; platelets, 310,000 per cu. mm.; bleeding time, 1.5″; clotting time, 22 minutes. His blood group was 2 Mocs.

He was transfused twice and on December 10, 1933, discharged, in spite of the negative family history, with a diagnosis of hemophilia.

On February 27, 1939, he was admitted again with a lacerated forehead. A pressure bandage controlled the bleeding, but when it was removed one week later, bleeding returned. At this time the bleeding time was 2″; clotting time, 12 minutes. He was discharged without transfusion 19 days later.

During the interval before his next admission, March 3, 1942, he had suffered from many swollen joints, apparently due to bleeding within the joint spaces. A swelling of the floor of the mouth started 24 hours prior to this admission. There had been no trauma to the face, but both ankle joints were so swollen he had been unable to walk for five days.

Physical examination at this time revealed a firm, tender swelling of the submental region. There was a massive dark swelling in the floor of the mouth, elevating the tongue almost to the hard palate. He was unable to close his mouth or open it any wider. There was mild respiratory distress.

Laboratory work at this time revealed mild anemia; prothrombin time, 25% normal.

He was transfused with fresh whole blood, but on the following day, despite transfusions, the respiratory distress was greater and a tracheotomy was performed and a #2 tube inserted.

Postoperative Course Stormy

His postoperative course was very stormy, complicated by frequent bleeding into the trachea from the operative wound, which was treated by numerous transfusions of fresh whole blood. The swelling of the tongue gradually receded and by March 6 had returned almost to normal and he was able to eat and talk. On March 8 he developed tonsillitis which slowly cleared with sulfadiazine. His tracheotomy tube was removed on March 10, 1942; however, there was more bleeding but no more transfusions were necessary. On March 18, 1942, his condition became critical again, apparently due to bleeding within the trachea. Of all of the various anticoagulants

*Associate in Pediatrics, University of Louisville School of Medicine.
†Associate Professor of Medicine, U. of L. School of Medicine.



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NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

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Research in the Service of Medicine

tried, whole fresh blood seemed to be the most beneficial.

On April 8, 1942, he again developed an acute pharyngitis which was treated successfully with oral sulfathiazole.

He received a total of 35 pints of blood.

Other significant laboratory data: Prothrombin time, 0.5-$\frac{12.02}{10.14}$ 0.4-$\frac{18.01}{18.10}$ 0.2-$\frac{20.10}{30.49}$ 0.1-$\frac{14.01}{22.05}$; Quick's modified method, 0.17-0.18 N.P.N. 28.19 mgm. per cent; specific gravity of plasma, 1.0299 and 1.025.

Prothrombin time ranged from March 4, 25%; March 19, 75%; March 28, 95%; April 4, 50%; April 10, 50%; April 20, 50%.

He was dismissed on April 20, 1942.

Hospitalized Eight Times

From January 24, 1943, through May 25, 1945, he was hospitalized on eight different occasions for bleeding into various joint spaces, especially knees, ankles and hips. Each transfusion, on the last admission, produced albuminuria and hematuria. Vitamin K seemed to influence the bleeding very little.

Since he had now passed the pediatric age, he was next admitted to the Louisville General Hospital on January 7, 1947, at the age of 15 years. He remained there 46 days due to hemorrhage in the recti and psoas muscles and right groin area. His bleeding time was 1:55″; clotting time, 30″, and prothrombin, 75.8%.

From May 21, 1947, to October 2, 1949, he had six admissions, mainly for hemorrhages in and around joint spaces. There was never a recurrence of his sublingual hemorrhage and his tracheotomy scar healed well.

On many of these admissions he had whole fresh blood transfusions, fraction of human plasma, rutin, ascorbic acid, etc., all without dramatic results.

From November 1949 to March 1954, he had 28 admissions characterized by hemarthrosis, hematuria and hemorrhages in various muscles, all requiring transfusion, sedation and, on one occasion, a padded cast to his right arm. Roentgenograms in 1953 revealed calcified right axillary nodes.

Discussion

Since 1910 there have been nine cases reported of sublingual hematomas as a complication of hemophilia in children. Of these nine, four had tracheotomy anl only one of these four survived. This is an extremely hazardous complication and requires most meticulous care and consideration, both by the physician and the nursing staff. Today, with the fresh frozen plasma in relatively unlimited amounts, the sublingual hematoma and/or the tracheotomy may possibly have been avoided.

In this case, the sublingual hematoma developed rather rapidly. In spite of fresh whole blood transfusions, dried plasma and all of the then known anticoagulants, the airway was rapidly cut off by the elevated tongue. The respiratory distress became an extremely marked manifestation, and it was the opinion of all concerned that tracheotomy was absolutely necessary. Following tracheotomy, fresh whole blood, largely with some dried plasma, was used again to prevent the hemorrhage. The control was fairly successful. Most of the plasma used at this time was commercial dried plasma which, of course, in all probability, contained relatively little anti-hemophilic activity. The blood used, however, was usually drawn and used within an hour or so, leaving its anti-hemophilic activity intact.

Summary

A case of sublingual hemorrhage as a complication of hemophilia is herein presented. This increases the total number of reported cases resulting from this complication from nine to ten since 1910.

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Dedication

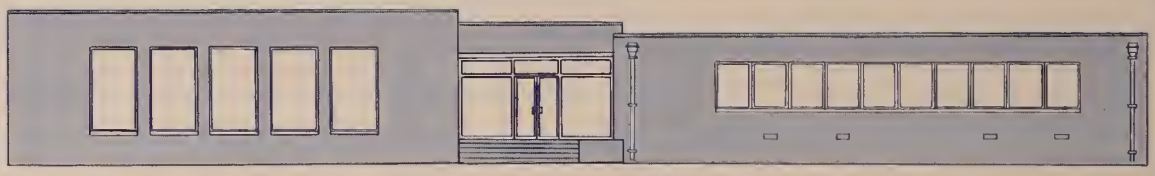
KENTUCKY STATE MEDICAL ASSOCIATION

Headquarters Office

Sunday May 20, 1962

3532 Janet Avenue Louisville, Kentucky





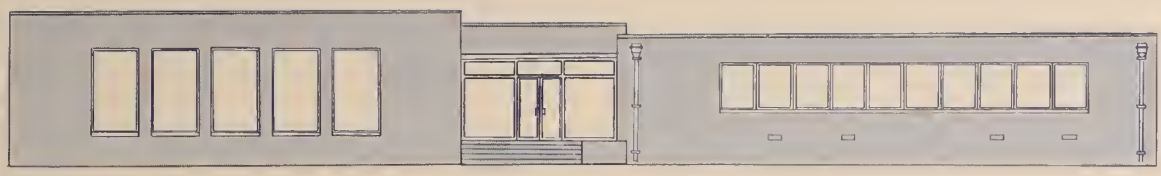
PROGRAM

Sunday—May 20, 1962

Call to Order	George F. Brockman, M.D., Greenville, chairman KSMA Building Committee
Invocation	Rev. Paul Stauffer, pastor, First Christian Church, Louisville
Opening Remarks and Introduction of Distinguished Guests	Dr. Brockman
Presentation of Keys to Building	Stanley Lichtefeld, general contractor
Acceptance of Keys	Gaithel L. Simpson, M.D., Greenville, KSMA President
Prayer of Dedication	Wyatt Norvell, M.D., New Castle, chairman, KSMA Board of Trustees
Remarks	Mayor William O. Cowger, Louisville Governor Bert T. Combs, Frankfort
"The Physician As A Citizen"	George M. Fister, M.D., Ogden, Utah, President-Elect, AMA
Cutting of Ribbon	Governor Combs

Tours of New Headquarters Office





A New Building – A Greater Potential for Service

A NEW chapter in Kentucky's medical history will open with the dedication of the new headquarters office of the Kentucky State Medical Association on May 20.

Designed to better serve the medical profession and the people of Kentucky, the new building will enable the Association to meet the demands of the future while maintaining the fine traditions of the past, according to Gaithel L. Simpson, M.D., Greenville, KSMA president.

Now in its 111th year of service to Kentuckians, the KSMA has 2091 members. This figure represents substantial growth over the years with a jump of about 10 per cent in the 11 years since the centennial celebration in 1951 when the membership totaled 1884.

Result of Foresight

Today's KSMA is the result of the foresight of 39 physicians who met in the Senate Chamber in Frankfort on October 1, 1851 to form a state medical group with W. L. Sutton, M.D., Georgetown, as its first president. The group was incorporated by the General Assembly as the Kentucky State Medical Society on November 24 of that year.

Originated for the purpose of advancing medical science and maintaining high professional skills, its aim has always been to provide the public with the best possible medical care. In endeavoring to carry out these objectives, the KSMA has continually expanded the scope of its activity.

At present, the headquarters office has a staff of 11 working a 40-hour week and many hours of overtime each year. Twelve years ago in 1950, there were only one full-time and one part-time worker carrying on Association activities.

Up until its 100th year the KSMA had no fixed annual budget. The assets in 1951-52 totaled $95,597, contrasted with the assets of $328,978 for 1961-62. Income for the operation comes for the most part from membership dues, medical journal advertisements, and sale of technical exhibit space at the Annual Meeting.

Providing a continuing program of education for the state's doctors has always been a KSMA project. The KSMA Annual Meeting has acquired a reputation for excellence through its top flight programs featuring physicians recognized as "expert" in their specialty fields, scientific exhibits of high calibre, and special features, including, televised surgical procedures and trans-Atlantic discussions.



The McCormick Home—Bowling Green
1907-1910

The KSMA acknowledges with appreciation the help of Emmet Horine, M.D., Brooks, and L. O. Toomey, M.D., Bowling Green, in supplying much of the historical information contained in this article.



Old Potter College Building—Bowling Green
1911-1919

Long heralded as the postgraduate event of the year, the meeting has an outstanding reputation and now draws attendance of 50 per cent of the membership; a good turnout in comparison with percentages achieved by other states.

To further postgraduate medical education, an office was set up under KSMA jurisdiction in 1959. The postgraduate office coordinates, instigates, and promotes PG medical programs in close cooperation with the medical schools and specialty groups. Formerly located at the University of Louisville Medical School, facilities at the new headquarters now house the postgraduate office.

Continuing Education

Another phase of continuing education for the physician is the scientific section of the Journal of the KSMA. Kentucky became the eighth state to start a medical journal when a monthly Bulletin was started in 1903 under the editorship of James Bullitt, M.D., Louisville. Before that time only the Annual Transactions had been published. Now it has grown to a 100-page publication which has continually upgraded its scientific contents and endeavored to give a comprehensive coverage of KSMA and other medical news. Each month it is estimated that Sam A. Overstreet M.D., editor, and George W. Pedigo, M.D., associate editor and other physician editors contribute 65 man hours in the interest of a better Journal.

In 1945 a program which the AMA has called "Kentucky's Pioneer Plan" was set up under KSMA direction and implementation. Since then, the Rural Kentucky Medical Scholarship Fund has granted loans to 223 medical students who have agreed to help meet the need for better distribution of medical care in Kentucky's rural areas.

Another project of importance to both the physician and the public is the KSMA Physician Placement Service which puts available physicians in contact with communities needing them.

The complex socio-economic problems of today and the greater necessity for medical public relations have imposed new duties on the Association. For the past 12 years, to meet these challenges, topics in these fields have been covered at an Interim Meeting (formerly the County Society Officers Conference). It is a working conference for both officers and members featuring speakers versed in the problems facing medicine in these vital areas.

Cooperation between the KSMA and the state's medical schools is close. In its concern for the physician of tomorrow, the Association sponsors an Annual Senior Day aimed at helping the seniors bridge the gap between book learning and actual practice.

Programs in the public interest are an important KSMA function. Each Fall it sponsors a unique, non-fund raising drive for diabetes detection and education. In the interest of health education, the KSMA conducts exhibits at the Kentucky State Fair, the Kentucky Education Association meeting, and other statewide conventions. KSMA is also active in the sponsorship and promotion of an annual "Immunization Week," an Athletic Injury Prevention Conference, and a Rural Health Pro-

Sixth and Main Streets (left foreground)—Louisville
The 1937 flood destroyed most of KSMA records
1919-1937





620 South Third Street—Louisville
1938-1957

gram and Conference. It backs legislation on both the state and national levels which it feels is in the public interest. Members of the staff also took an active role in the development of an indigent care plan in the state.

Governing the KSMA is a House of Delegates and a Board of Trustees elected from the membership and representing the various county societies and all areas of the state. Officers of the Association are also elected on a statewide basis by the House, with the presidency going alternately to physicians in the central, eastern, and western sections of the state.

Under a new committee structure voted by the House in 1960, in a few months time, association activity increased approximately 15 per cent. In the nine months preceding the 1961 Annual Meeting, 463 members traveled an estimated 74,000 miles to spend more than 2,300 hours in 64 formal meetings.

With a record of seven AMA presidents* from the Association through the years, the KSMA has made notable contributions to medicine on the national level. KSMA's voice in AMA affairs is represented by delegates to the AMA House of Delegates who are elected from the KSMA House.

Members of the staff write the Secretary's Letter, Newcaps, news releases and other promotional material and speak before civic and other groups. The Executive Secretary's Report of 1961 estimated that during the year the staff saw 2,000 people in the office, handled more than 7,800 phone calls, and got out approximately 65,000 pieces of mail. At the same time, staff members represented KSMA at 100 meetings of state groups concerned with health and welfare. Executive members of the staff also attended 25 national and regional meetings.

With the demand for KSMA services at a heightened tempo and the prospect of future expansion apparent, members began to explore the possibility of a new headquarters building. In 1959 the Muhlenberg County Medical Society introduced a resolution in the KSMA House recommending the appointment of a building committee. The committee, headed by George Brockman, M.D., Greenville, brought a recommendation for a new building to the 1960 house. The measure passed unanimously.

Plans for the contemporary brick building which will accommodate all KSMA activity now and in the years to come, were drawn up by Nevin and Morgan, Architects, with Herbert Weber, the architect in charge. Hubbuch of Kentucky handled the interior decoration.

Combining attractiveness with utility, the new building in its approximately 7,000 square feet of floor space encompasses adequate planning for efficient work space, use of machines, and future expansion, according to Doctor Brockman.

Comprised of two wings—one housing the executive offices and the other the administrative services—the building will provide ample space for trustee and committee meetings. Planned with the advantages of being able to meet within the headquarters office in mind, the executive wing has a board room covering approximately 1,000 square feet of space, an office for the president, and kitchen facilities which both a caterer and the staff can use.

The administrative side also has space for committee meetings and in the 12 rooms located on that side all of the Association's administra-

Medical Arts Building—Louisville
1957-1962



They were: Henry Miller, M.D., 1859; D. W. Yandell, M.D., 1872; J. M. Mathews, M.D., 1899; L. S. McMurty, M.D., 1905; Irvin Abell, M.D., 1938; Fred W. Rankin, M.D., 1942; and Elmer Henderson, M.D., 1950.



tive functions are carried out under the direction of J. P. Sanford, the executive secretary. Also in the administrative wing are the offices of the Rural Kentucky Medical Scholarship Fund, the Postgraduate Medical Education Office, the Journal, Physicians Placement, and Woman's Auxiliary.

A spacious basement of 2,100 square feet provides the building with additional work and storage space as well as a fallout shelter. Twenty cars can presently be accommodated in the parking lot adjoining the building and there is plenty of space for increased parking facilities should the need arise. In describing the building and surrounding area, President Gaithel Simpson, M.D., noted that all phases of the new headquarters provide for future expansion.

Located in the northwest quadrant of the Watterson Expressway-Taylorsville Road interchange, the new structure at 3532 Janet Avenue is easily accessible both to physicians in Louisville and throughout the state.

Work on the $150,000 KSMA home was started by Fred J. Lichtefeld & Son, Contractors following ground breaking ceremonies on May 21, 1961, which featured an address by Lt. Gov. Wilson Wyatt. Members of the staff moved into the new KSMA home on January 26 of this year.

The new building is the first "real" home of the Association though it has had at least five official offices prior to its latest move. Previously, the KSMA has either rented space or been housed with the State Department of Health, since for many years the secretary of the Association was also the Commissioner of Health.

First in Bowling Green

First KSMA office on record was at the McCormick home on Twelfth and State Streets in Bowling Green. It was first used as the Association office when Arthur T. McCormick was made KSMA secretary in 1907. There is some feeling that an earlier office may have been located at the McCormick home on Tenth and State Streets in Bowling Green which burned in 1895, but there is no verification of this in KSMA history.

In 1911 a small cottage on Twelfth Street, Bowling Green served as headquarters for several months until a move to the old Potter College Building on the Western campus was made in October, 1911, to meet the need for expanded public health services.

First office in Louisville was at the southeast corner of Sixth and Main Streets. The move to Louisville was made in 1919 and it was in this building that most of the KSMA records were lost in the 1937 flood.







Following the flood, the offices of the KSMA and the Board of Health were moved to the building formerly occupied by the Federal Land Bank at 620 South Third Street in Louisville. Dedication of the building as the Joseph Nathaniel McCormick Memorial took place on October 4, 1938. It is expected that the original plaque which noted that the Association was housed in the building will be used on the new building.

Just before the 1957 Annual Meeting, the KSMA office of seven employees moved from the State Board of Health building to the Medical Arts Building on Eastern Parkway in Louisville. This building which houses more than 100 physicians' offices served as the KSMA home until the move to the new building in January of this year. KSMA rented space on the first floor.

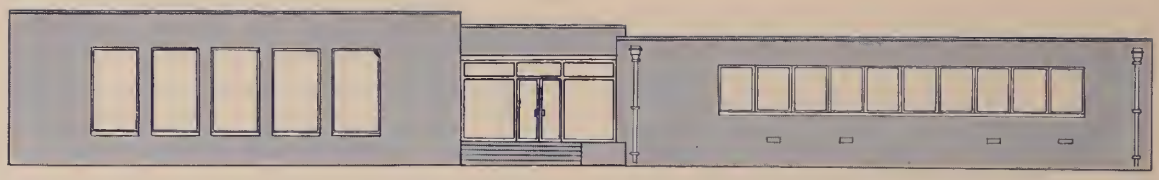
A new era in Kentucky's medical history starts with the dedication of the new headquarters on May 20. Built on the firm foundations of the past, the building reflects the integrity of the medical profession and its intention to continue to work to provide for the health and welfare of the people of Kentucky.



First committee meeting at new headquarters
Advisory Committee to the Editor



Ground Breaking—May 21, 1961
Immediate Past President—Richard G. Elliott, Jr.



Building Committee's Planning Made Building A Reality



N. Lewis Bosworth, M.D.



George Brockman, M.D.
Chairman



Hoyt D. Gardner, M.D.

Many hours of hard work, travel, and attendance at numerous meetings over a two-year period tell the story of the role the KSMA Building Committee played in making the new KSMA headquarters office at 3532 Janet Avenue, Louisville, a reality.

To plan the various aspects of the KSMA headquarters office, the groundbreaking, and dedication ceremonies, the committee held 17 formal meetings and several informal sessions from December 16, 1959 to February 22, 1962. Another meeting scheduled at press time was to be held on April 26.

The Committee

With George Brockman, M.D., Greenville, as chairman, and including N. Lewis Bosworth, M.D., Lexington, and Hoyt Gardner, M.D., Louisville, the committee has worked both on the scene and behind the scene discussing, planning, and making recommendations on every aspect of the new structure.

The KSMA Board of Trustees has voted to express the official appreciation of the Association for the excellent work they have done. Commenting on this action of the Board, KSMA President Gaithel Simpson, M.D., Greenville, said, "Their recommendations on all features of the building represented thoughtful study and foresight and the entire Association certainly owes them a vote of thanks for work well done."

Realizing the value to be gained from the experience of others, the committee, accompanied by the KSMA Executive Secretary and the architect Herbert Weber, visited three medical associations that had recently constructed new headquarters offices. These visits—to the Mississippi State Medical Association in Jackson, the Alabama State Medical Association in Montgomery, and the Tennessee State Medical Association in Nashville in February, 1960—helped the committee immensely Doctor Brockman said, and were a major factor in giving direction to the committee in its planning.

Information Gained

From these visits and correspondence with these and other associations, the committee not only learned some of the things which should be included, but also some of the things which should not be done. This information, together with practical recommendations of staff members and a study of the needs of the KSMA, enabled the committee, after innumerable sessions, to plan every phase of the new building from the most minor point to those of major import.

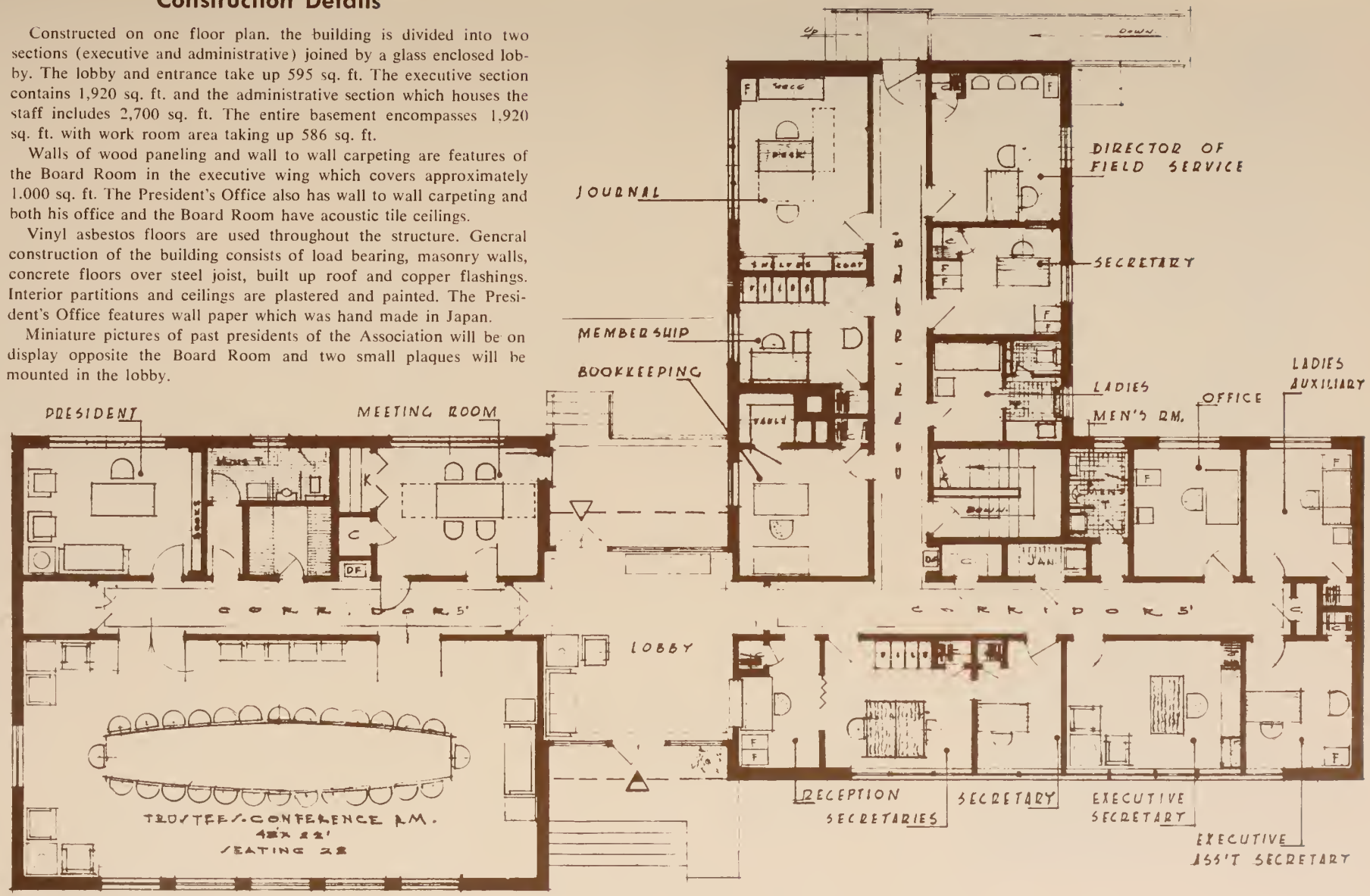
Construction Details

Constructed on one floor plan. the building is divided into two sections (executive and administrative) joined by a glass enclosed lobby. The lobby and entrance take up 595 sq. ft. The executive section contains 1,920 sq. ft. and the administrative section which houses the staff includes 2,700 sq. ft. The entire basement encompasses 1,920 sq. ft. with work room area taking up 586 sq. ft.

Walls of wood paneling and wall to wall carpeting are features of the Board Room in the executive wing which covers approximately 1,000 sq. ft. The President's Office also has wall to wall carpeting and both his office and the Board Room have acoustic tile ceilings.

Vinyl asbestos floors are used throughout the structure. General construction of the building consists of load bearing, masonry walls, concrete floors over steel joist, built up roof and copper flashings. Interior partitions and ceilings are plastered and painted. The President's Office features wall paper which was hand made in Japan.

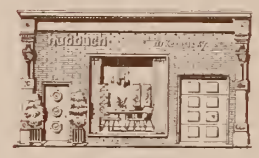
Miniature pictures of past presidents of the Association will be on display opposite the Board Room and two small plaques will be mounted in the lobby.



Congratulations &

Best Wishes to

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1962 KSMA ANNUAL MEETING

SEPTEMBER 18-19-20

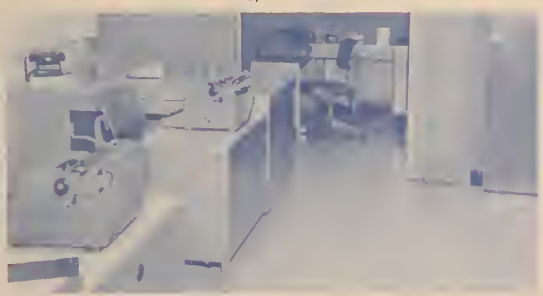
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President's Office

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SPECIAL ARTICLES

Report on The AMA House of Delegates

GEORGE F. BROCKMAN, M.D.
Greenville, Ky.

IN MARCH 1961 it became apparent that membership in the Kentucky State Medical Association had grown sufficiently to merit the Association an additional representative in the House of Delegates of the American Medical Association. Because the State Association holds elections in September, there would be an interval of nine months before a properly-elected delegate could begin service. To fill the interim vacancy, the Board of Trustees designated a small town physician, 25 years a member of the Association, who had never sought elective office. As that non-political delegate, I thank the Trustees for the privilege and submit this report of my observations during this brief tour of duty in the highest echelon of medical leadership.

This report was prepared for the Board of Trustees of the Kentucky State Medical Association and in the meantime a copy was forwarded to The Journal of the American Medical Association which used a substantial portion of this material in the February 10, 1962, issue.

Structure of the AMA

Membership in the AMA is the prerogative of every physician who is a member of a component medical society and who undertakes the payment of AMA dues. The policy-making body of the AMA is the House of Delegates, composed of representatives of the component societies. Each State Association is entitled to representation by one delegate for each thousand (or fractional thousand) dues-paying AMA members. In addition, physicians entitled to AMA Service membership, by virtue of employment in the Army, Navy, Public Health Service and Veterans Administration, are represented by one delegate from each service, designated by the surgeon general of each Service. Each of the Clinical Sections of the Association is allotted representation by a delegate, and the Student AMA is allotted representation by their national president and vice-president who do not vote. On retiring from office, a president of the AMA becomes a life member of the House.

Elected officers are the president, president-elect, vice-president, speaker and vice-speaker. These, and the Board of Trustees, conduct the business of the Association when the House is not assembled. There are nine trustees, elected successively to terms of four years each. In addition, standing committees of the House designated variously as committees, commissions or councils, maintain continuous programs of study and work in various special fields. Special committees are created as needed to fulfill specific tasks. Beyond this, the Board of Trustees and/or the speaker of the House of Delegates appoint committees for special purposes to aid them in the discharge of their duties.

Following formal opening of a session of the House of Delegates, the matters of Association business are presented in the form of reports of officers, trustees, committees and as resolutions introduced from various component societies or from the delegates themselves. In the June 1961 meeting, each delegate was confronted with the consideration of these matters in a volume of approximately 500 typewritten pages. To make useful decisions on this volume of material requires the House to use rigid self-discipline and to observe parliamentary procedure meticulously.

As the physical embodiment of the AMA, the delegates deserve special study. Lacking both the courage and wisdom to attempt to typify or average the members of any group of 250 physicians, I will attempt to identify their more important common attributes.

The delegate will be approaching, or past, 50 years of age. He is successful in his field of medical endeavor and has either the means or other facilities that allow him to spend from 10 to 30 unpaid days each year in the service of the Association. He will have demonstrated qualities of leadership in local and state medical affairs and may well have previously served as president of his state association.

In a few instances, he will be found to be serving for purposes of social enjoyment or prestige. In the vast majority of cases, the delegate is serving with a sincere desire to contribute to the progress of organized medi-

cine; and in many instances, he feels that he can best serve if he attains a position of leadership in the House.

The delegate may be feminine, as women physicians serve in the House in about the same proportion as in the general membership.

The delegate may be a Negro. Dr. Peter Murray of New York, after years of valued service in the House, served as chairman of an important reference committee at the June meeting. The House awarded him complete equality by amending the recommendations of his committee as freely as they did those of his white colleagues.

An outstanding attribute of the delegate is approachability. Both in becoming a successful physician, and by securing election to his present office, he will have demonstrated attractive personality characteristics. Uniformly, he makes every effort to become acquainted with, and help, newcomers to the House. If, as may be surmised, there is a considerable element of appraisal behind this friendly hospitality, I accepted it as occasioned by a concern for the capabilities of the House.

Reference Committees

The second day of each meeting is devoted to hearings by the reference committees. Each committee is composed of a chairman and four other delegates. Hearings are formal. The time and place of the meeting of each committee is widely publicized. Each committee must consider, in serial order, the items referred to it. Before the consideration of any item is concluded, the chairman makes sure that no witness desiring to testify remains unheard. Any member of the Association must be allowed to express himself and non-members may be heard by permission of the chairman. The reference committee is interested in all shades of opinion, and I would feel that any non-member who had information of interest to the Association would receive a hearing.

After publicly considering each item referred to it, and hearing all evidence which might be available, the reference committee in executive session prepares a report for submission to the House. This report must summarize the committee findings on each item and recommend a course of action.

This report, when adopted by the House either in the original committee form or with amendments, becomes the official action of the American Medical Association.

Self-Perpetuating Leadership?

The higher officers of the AMA, as a group, show a considerable degree of cohesion and a similarity in thought and action. An explanation frequently heard, but seldom documented, is that they constitute a self-perpetuating body of rulers of American medicine. According to this concept, the closely-knit coterie occasionally reach down to draw unto themselves another like member, as the group may need replenishing. While this thought is attractive in explaining some superficial resemblances, it totally neglects some of the more salient characteristics of the House of Delegates.

As a parliament, composed exclusively of experienced organizational workers, the House is quite demanding of its leaders. The contest for leadership is a perpetually attractive challenge to some of the strongest, most intelligent and most ambitious medical personalities in America. Progression in leadership is slow, even for the talented. A new delegate does not ordinarily serve on reference committees during his first year. He is not usually designated as chairman of a reference committee in less than five years. Trusteeship is only exceptionally the reward of less than eight to ten years of diligent work.

The delegate who attains a rung on the ladder of leadership is keenly, if not apprehensively, aware that his stewardship of office is under constant critical appraisal by competent peers, many of whom are qualified and eager to supplant him. He circumspectly concentrates on adequately discharging the duties of his office, being well aware of the hazards if he should unsuccessfully attempt to influence the House in its choice of junior officers.

Cohesion From Below

My interpretation is that the cohesion and observed similarity in the top leadership is imposed from below, by the House. As an individual tends to progress up the ladder, he does so only as he develops, on the basis of experience, observation or intuition, the stature which the House regards as fitting for his next office.

In the June elections, one candidate was overwhelmingly defeated because the House felt that he was (as the record confirmed) presumptuously reaching beyond his attainments in a too brief span of service. Another delegate, quite talented, and with an outstanding record despite his few years of service, definitely discouraged an influential group of friends from nominating him for a significant office, lest he should be thought presumptuous.

It would seem that at least 70% of the elections are determined on the basis of seniority of competent service and the general popularity of the candidate.

The only evidence of machine politics which I could specifically identify was in a contest for very high office. In this instance the machine was attempting only negative control in successfully undertaking to stop the front-running nominee. As documented elsewhere, the machine had some difficulty in securing a candidate to accept its obviously powerful support.

For insight into the election mechanisms, I participated actively in the campaign for one nominee who was the valued associate of a personal friend. All delegates whom I approached listened courteously to my advocacy, asked intelligent questions regarding the record and attainments of my nominee and in no case conditioned their support on a *quid pro quo*. Since my candidate had been, for years, tremendously popular, his majority exceeded the support which I had solicited. I regard this as evidence that my amateurs researches had no influence whatever on the course of American medicine.

Disciplined But Independent

Although willing to accept rigid self-discipline as to procedure, the House is absolutely independent in action and independent in judgment. It is merciless

in judging the leadership offered to it. A characteristic example is the fate of the Committee on the Relationship Between Medicine and the Allied Professions. This committee, appointed by the trustees after long investigation and deep study, submitted a report on its findings and recommended action to the trustees. The trustees, in forwarding the report to the House, approved and recommended the action proposed. The reference committee which reviewed the report heard lengthy testimony and in preparing their report to the House also approved of the proposed action. Despite these endorsements, the House was not pleased. It directed that another committee, to be appointed by the Speaker, restudy the problem for a solution more in keeping with the will of the House.

Another instance in which the House directly contravened its leadership was in the selection of the site for the winter meeting of 1963. A committee of the Board of Trustees had reviewed the facilities at various western cities and recommended that Las Vegas be awarded the meeting. The Board of Trustees approvingly forwarded this recommendation to the House of Delegates. The reference committee also recommended this action to the House. The House overwhelmingly rejected these thoughtful recommendations and chose Portland, Ore., as the meeting site. In the discussion on the floor it was apparent that no moral judgment was involved in this decision.

Sense Of Delegated Responsibility

The single most impressive characteristic of the psychology of the House is a deep sense of delegated responsibility. This is demonstrated in the feeling that any expression of the constituents is sacrosanct. In June, as directed in a resolution by one of the state associations, the House gravely stood and was counted in overwhelmingly rejecting any extension of Social Security coverage to physicians. This merely reaffirmed a decision that had been made many times before. If another delegation presents similar instructions at the next meeting, the House will again vote.

This sense of delegated responsibility, while representing the acme of democratic representative government, has some aspects of an almost pathological state. It was slightly disturbing to observe mature physicians, competent and accustomed to the responsibility for making tough-minded decisions daily in the lives of their patients and in their own affairs, cast an almost literal backward glance over their shoulder with the feeling that the boys back home are watching.

The Board of Trustees, for instance, is, if anything, over-meticulous in explaining and justifying its actions to the House. This has, it would appear, the specific disadvantage of adding greatly to the burden of detailed reports, and the very volume of words tends to lead the House to a loss of perspective. Prolonged consideration of relatively trivial matters may lead to inadequate deliberation on more important subjects toward the end of the session, when time makes the decisions as the delegates hurry toward adjournment. While this is a purely subjective area of judgment, it appears probable that a wise man from Mars might conclude that this lack of confidence in leadership is a disadvantage to the long-range welfare of American medicine.

Doctor Jones Expresses Himself

We may well consider a truly basic question: How well does the AMA represent the individual physician? Occasionally, in medical circles, one hears charges of "oligarchy" and "monopoly." More commonly, such comments arise from lay sources who attempt to promote the concept that the "medical trust" is somehow a different creature from Doctor Jones, dispensing care and sympathy in his office beside the corner drugstore.

Any member has at his command numerous channels for influencing the AMA policy: By local action he influences both the choice of delegates and the specific instructions which may be given to them. By personal expression he may influence an AMA committee or council which may be studying the field in which he is interested. Formally and absolutely, he has the right of appearance before a reference committee of the House of Delegates. It is hard to conceive the need for additional mechanisms to promote more democratic action.

That Doctor Jones does express himself was apparent in the June meeting of the House, where over 100 resolutions from constituent associations were introduced. In the November meeting, an unusually large number of delegates were recognized as terminating their tenure of office. These retirements (the majority of them involuntary) included several delegates with outstanding records of service as well as seniority. Whether these changes represent a broad pattern of unrest and dissatisfaction with Association policy or a chance combination of local conflict, unrelated to matters of policy, will be apparent only after the next meeting of the House.

Richard G. Elliott

1907-1962

Richard G. Elliott, M.D., immediate past president of the Kentucky State Medical Association, died at his home at Lexington, February 25, after a long illness. He was a pediatrician.



Doctor Elliott was born at Lexington November 11, 1907, the son of E. Cronly Elliott, D.D.S., and Mary Louise Love Elliott. He attended Lexington public schools and was graduated from the University of Kentucky with an A.B. degree in 1928. He received his M.D. degree from Vanderbilt University School of Medicine in 1932. He interned at Charity Hospital, New Orleans, La., 1932-1933; was assistant resident at Children's Hospital, Cincinnati, 1933-1934 and assistant resident at Children's Hospital, Philadelphia, 1934-1935.

Doctor Elliott started the practice of pediatrics at Lexington in 1935. He served in the U. S. Army from January 1941 to October 1945, entering the service as a first lieutenant in the Medical Corps and retiring from the service as a lieutenant-colonel. He later became a colonel in the Medical Corps reserve.

A Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics, Doctor Elliott, in addition to serving as KSMA president in 1960-61, also had served as president of the Fayette County Medical Society and as chairman of the Fayette County Board of Health. He was a member of the American Medical Association, the Southern Medical Association and the Dudley Journal Club.

Doctor Elliott was a member of the staff of Lexington's three general hospitals, Good Samaritan, St. Joseph and Central Baptist, and of Cardinal Hill Convalescent Hospital and the Baby Health Service.

In his many years of active service in KSMA, he served as a delegate to the House of Delegates from 1954-1959; was vice-president (Eastern District) in 1958; councilor of the Tenth District in 1959, and chairman of the Association's Committee on Public Information and Service from 1952-1958.

Doctor Elliott was a member of the First Methodist Church, the Lexington Rotary Club, the Kentucky Civil War Round Table, Pi Kappa Alpha Fraternity and Phi Chi Medical Fraternity.

He was married to the former Virginia O'Rear and is survived by his wife, three sons and one daughter.

Doctor Elliott's deep loyalty to his profession, his willingness to accept responsibility and his efficiency in discharging it, plus his broad experience as a leader made him a highly valued member of KSMA who will be sorely missed.

EDITORIALS

A Symbol of Past and Future Service

THE KSMA's beautiful new contemporary style office symbolizes the Association's continuing role of service to the people of the State.

It is an indication of the Association's determination to continue its job of providing the best possible care for the people of Kentucky and is the realization of a dream which interested members have had for a period of 10 years. A permanent office structure based on the sound achievements of the past, the building, besides providing efficiently for expanding operations, will also serve as a constant reminder of the KSMA's intention to serve.

With Louisville's modern expressway system, the building is within easy reach of both its physician members and the public it serves. Located just off the Watterson Expressway at the northwest quadrant of the Taylorsville Road exit, it is not only easily accessible, but is also in clear view of all who pass it on the expressway. It offers Kentuckians visible evidence of the Association's presence and its desire to expand its operations and to grow.

Looking back through Association history, we note the foresight of the physicians who met in Frankfort in 1851 to found the KSMA for the purposes of advancing medical science and providing the best possible medical care for the people of the State. Looking toward the future, it is not unlikely that tomorrow's physicians will in turn applaud the foresight of today's KSMA members who recognized the need for a new building designed to meet the challenges of the future and to keep pace with medical progress.

The new KSMA building truly symbolizes the Association's past and future service to society.

Gaithel L. Simpson, M.D.

*See the article on the building which starts on page 373.

* * * * * *

(The Editorial reproduced below is taken from Volume 1, Number 1 of the bound copies of the Journal of the Kentucky State Medical Association as part of the Dedication issue. Date is June 1903.)

EDITORIAL SALUTATORY

The Publication Committee begs leave to submit the following: The House of Delegates of the Kentucky State Medical Association gave discretionary power to the society's Publication Committee, acting in conjunction with the Council, to change the form of publication of the transactions of the Association from an annual volume to a monthly bulletin, or journal. In other words, instead of a much-delayed volume of transactions, which usually reaches the members so long a time after the annual meeting as to be already defunct on reception, the papers read at the annual meeting of the Association are to be journalized, will be published monthly, three or four at a time, and will appear so persistently and in such a live form, that they will be received with much greater interest and anticipation than the old volume of transactions.

This bulletin will also publish interesting and desirable papers which are read before the various county societies of the State, and will contain State and county news pertaining to medical topics. Its function will further be to not only encourage and stimulate organization in the counties where the medical practitioners have not yet gotten together, but also to cement and hold together more firmly the organizations which have already been effected. To this end, county news and county society reports, as announced in another column, will be encouraged. The Bulletin will concern itself with anything and everything which has interest for, and relation to, the medical practitioners in the State of Kentucky. If the officers of the

State Association, or of the State Board of Health, desire to communicate with every physician in the State of Kentucky, the Bulletin will be the certain means of carrying the message. In this way a united and concentrated action of all the physicians in the State can be obtained, a thing possible in no other way. Such unity and concert of action would mean the wielding of a power which those who have not studied the subject of organization are not able to compute at its full value. It would mean that the physicians of the State of Kentucky, acting harmoniously together, could secure the enactment of any law, or laws, necessary for the public good and the proper protection of themselves. More than this they would never desire.

Journalization of the transactions has already been instituted by the State Associations of Michigan, New York and California, and in each instance with the result of the greatest encouragement and satisfaction. The adoption of the plan of the State and county organizations recommended by the American Medical Association has already stimulated in a wonderful degree membership in the Kentucky State organization, and the new conditions engendered by these changes demand new treatment. Of these new demands it is confidently believed none is more imperative than this change in the form of publication. The only objection which can be offered to the plan is that offered by some members of the Council, who, in organizing county societies in their several districts, promised that the new members should, on payment of the stipulated annual due fee, receive a volume of Transactions, bound in red. These councillors fear that the members so promised will not be satisfied with the new arrangement, and even dread to again venture into the fastnesses of certain councillor districts.

Just at first there may be, perhaps, some disappointment in some quarters, but it is practically certain that a few months' time will convert all into friends of the new plan, and then these fearsome councillors will find smiles awaiting them instead of wrath, and will hear on all sides the words of satisfaction and praise, "You did *more* for us than you promised."

The question of expense for the publication of transactions by any plan is one of importance, and the members of the State Association are entitled to know what becomes of the money paid in dues, and to demand that the best possible return be made therefor. Last year the Kentucky State Association paid $578.00 for four hundred and ten volumes, bound in red, and these volumes were delivered just in time for this year's meeting. This year, under the new plan of organization, membership in the Association has jumped from four hundred to about thirteen hundred, so that the cost of a volume this year would be much greater than it was last year. Two of the three State journals already established report that the advertisements secured about pay the costs of publication and mailing, while the third journal, which is undertaken on a somewhat more extended scale, and includes a State directory, finds the issuance of the publication an actual expense, though not greater certainly than would be sustained in the issuance of a volume. When it is considered that medical journals as private enterprises can be, and are, made profitable investments, there certainly would seem to be no reason why a State journal could not be made at least self-sustaining. In Kentucky it starts out with a subscription list embracing the membership of the State Association, which is now, as already stated, and as can be verified by reference to the reports of the county societies, some thirteen hundred strong. But it is not proposed to stop here. Under the postoffice regulations a number of copies, equal to the number of paid subscriptions, can be entered as second-class matter. This will make it possible to send a copy of this bulletin to every regular practitioner of medicine in the State. If the mountain will not come to Mahomet, Mahomet must go to the mountain. The Bulletin does not propose to hide its light under a bushel, nor to conceal its blushing face behind a fan, like a bashful girl. On the contrary, it proposes to invade the camp of the enemy—for those who are not with us are against us—and to keep on the trail of every regular practitioner in the State who is not already a member of the Association until he has joined its ranks; and after that it proposes to still keep after him to keep him from backsliding.

In the discussion before the House of Delegates regarding the question of continuing to issue a volume of Transactions, or changing its form to a monthly journal, or bulletin, Dr. L. S. McMurtry, for many years a trustee of the American Medical Association, recalled the first meeting of the trustees at which the subject of establishing an American Medical Association Journal came up for discussion. The prop-

osition was regarded very dubiously, and it was almost with fear and trembling that it was finally undertaken. Last year the journal of the Association realized a profit of forty thousand dollars!

In conclusion, it is desired to lay emphasis on the fact that the officers of the State Association are the servants of the organization, that the Bulletin is its mouthpiece. To the end that both officers and journal may best and most efficiently serve the Association, suggestions about anything, criticism if you will, are solicited, and will find place in the correspondence column of the Bulletin.

* * *

In accordance with a resolution adopted by the council of the Kentucky State Medical Association, at its annual meeting in 1903, the following communication has been sent to the seven medical colleges located in the city of Louisville. This list includes the Southwestern Homeopathic College, and the National Medical College (colored):

May 14, 1903

Dear Sir: The following resolution was at its last meeting, adopted by the Council of the Kentucky State Medical Association, to-wit:

Resolved, That a committee of three, with the chairman of the Council as its chairman, be appointed to confer with the faculties of the Louisville medical colleges in regard to arranging for a course of lectures in all of them as to the necessity of medical organization, the relations of physicians with each other, their patients and the public, and proper business methods in the management of their professional work; such lectures to be delivered at least once a month in each college, and that the lectures shall be the same in all the colleges, if possible, and that the committee report to the Council at its first meeting the result of its labors.

The committee begs leave to submit this resolution to you, accompanied with the request that you lay the matter before your faculty, together with the assurance that it will be pleased to confer with your faculty, or its representative, at your convenience. Awaiting your pleasure, and urging prompt consideration of this very important subject,

We are respectfully,
Jno. G. Cecil, Chairman
W. W. Richmond
R. C. McChord
Committee.

(This ends the reproduction of the first editorial from Volume 1, Number 1 of the Journal of the Kentucky State Medical Association

* * * *

The Kentucky Resolution

GOVERNOR Combs has signed a strong resolution passed in both houses of our recent legislative assembly calling automobile manufacturers to task. Subordination of passenger survival to electrically lighted ash trays is recognized by summoning the industry "to incorporate in all American motorcars those devices and structures *known* to be capable of reducing the number of highway deaths and injuries."

Many sound principles of medical, safety and deceleration engineering have been well documented and published for more than two decades yet curiously avoided by the builders.

The Kentucky Resolution calls for no expensive research grants or visionary schemes. It asks the manufacturer to do only what is already *known* to be wise and needed.

Of the approximately 6,500,000 new cars being put on our roads annually, nearly half will be involved in injury-producing crashes at some time. The annual toll of injury runs to nearly 3,000,000 people. Prevention is the only remedy for automobile injuries—and almost any accident could be made survivable.

After 20 years of design campaign by Michigan's Claire Straith, Virginia's Fletcher Woodward, Kentucky's Arnold Griswold, and other traumatologists, the 1962 Chevrolet sports a sharp metal "head wedge" jutting out from the dash. The 1962 Dodge angulates its dash directly toward passengers in the "suicide seat." Buick, at best, will flimsily pad the upper of its two sword-like dash rims.

Projecting radio knobs and window controls are standard equipment. Electrical systems to operate windows of non-laminated glass are increasingly frequent. Several local dealers did not know whether their cars did or did not have laminated safety glass. The industry quietly removed this type of safety glazing from side and rear windows in 1959, saving $5 to $15 per unit.

Huge advances have been made in commercial, energy-absorbing materials such as "Ensolite," "Hexcel honeycomb," and aluminum foam. Nine of these are incorporated into

(Continued on Page 427)

ORGANIZATION SECTION

KSMA To Observe Immunization Week May 1-7

Immunization Week in Kentucky will be observed this year May 1-7, according to Delmas M. Clardy, M.D., Hopkinsville, chairman of the Public Health Committee of the Kentucky State Medical Association. Purpose is to achieve, as nearly as possible, complete immunization in the State against polio, diphtheria, pertussis, tetanus, smallpox and typhoid fever.

All KSMA members are asked to cooperate in making the week a success, and physicians are urged by Doctor Clardy to check the immunization records of families under their care with especial emphasis on the children. The Week is sponsored by KSMA and other statewide organizations.

KSMA members will be asked to urge their patients to keep their families' immunizations up to date; patients will be urged to carry the message to their neighbors.

While the KSMA points out that children need immunization most, adults, also, should keep track of their own records particularly typhoid, tetanus, diphtheria and polio which are no respecters of age.

H.B. 236, the KSMA's compulsory immunization bill was signed by Governor Bert T. Combs and will become law in June of this year. Russell E. Teague, M.D., commissioner of health has estimated that approximately 500,000 elementary and high school students under 18 years of age must receive the immunization shots in order to enter school in the fall.

Opening Date of April 24 Chosen For U. of K. Hospital

The University Hospital and Clinic of the University of Kentucky Medical Center, Lexington, is scheduled to admit patients on a limited basis beginning April 24, according to Dean William R. Willard, M.D. Initially, the Outpatient Clinic and 64 beds on the fifth floor of the Hospital will be activated, providing both outpatient and inpatient services for medical, surgical, pediatric and some psychiatric patients.

It is anticipated that another 38 beds will be activated early in July; another 17 beds in October, and that around the first of the year, about 143 beds will be in operation.

Admission to the patient care facilities of the Hospital, except for emergencies, will be determined by the needs of the teaching and research programs of the Medical Center and by the needs of patients for the particular facilities and resources available in the Medical Center.

As a general policy, all patients, except emergency patients, will be referred by a licensed physician or dentist and will be treated within the patient care and teaching programs of the Center.

Arrangements for referrals should be made in advance and may be made directly to the admitting office of the University Hospital and Clinic or to a physician who is a member of the faculty. The phone number of the Admitting Office is 5-3648, extension 2911.

Will Provide Information

Referring physicians will be expected to provide as much relevant information as possible about the medical condition of the patient prior to or at the time of admission. Health and welfare agencies referring through a physician will be expected to provide pertinent social and economic information.

The University Hospital's Admitting Office will confirm all arrangements with the patient and with the referring physicians as indicated, and referring physicians will be sent summaries at the time of the patient's discharge from the University Hospital.

A leaflet containing more complete information about the University Hospital has been mailed to each physician in Kentucky. Copies of this leaflet are available from the Division of State and Local Services, University of Kentucky Medical Center or from the Admitting Office, University Hospital and Clinic.

Dean Willard told members of the Kentucky State Medical Association Committee to the U. of K. College of Medicine at the Owensboro Interim Meeting that the Hospital would be available to patients regardless of their economic status and their geographic residence within the State.

Many Appointments Made

Dean Willard said a large number of voluntary faculty appointments to the U. of K. Medical Center staff had been made especially in the Departments of Medicine and Surgery and that the list includes many prominent physicians in the Lexington area.

The College of Medicine, according to Dean Willard, has accepted 40 students in its first class and 60 in its second class. The oldest student admitted was 35 and the youngest 19; the average age was between 23 and 24. Ninety-five of the students are men, five are women. Fifty-nine were married at the time of admission. Of the total number of students: 43 came from rural Kentucky, 41 from urban Kentucky, 14 from out of the State and 2 from foreign countries.

Dean Willard said that he and the chairmen of the



If you had to make your own children's multivitamins

...chances are you'd try to make them very much like our **new VI-DAYLIN® CHEWABLE with Entrapped Flavor.** Entrapped Flavor means a better tasting chewable children's multivitamin; one with no vitamin aftertaste. Here's why: 1. We coat all the vitamins in a digestible film that does not dissolve until it reaches the gastrointestinal tract. This means that unpleasant strong vitamin tastes are not released in the mouth, but in the g-i tract where they are most quickly absorbed. 2. We make certain that every Vi-Daylin Chewable tablet tastes citrus sweet and good to every patient, every time; we coat the flavoring oils in each tablet in a water soluble film. This film dissolves immediately in the mouth, releasing the full bouquet of our citrus-candy flavoring agents. Now you know why little patients always taste the flavor, never the vitamins, when you prescribe new Vi-Daylin Chewable. And the formula's all you'd expect, with reasonable amounts of A and D. Taste test them yourself and you'll prescribe **VI-DAYLIN CHEWABLE** regularly and soon.

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Profile of a multivitamin



New Vi-Daylin Chewable —with entrapped flavor

New Formula

In recognition of recent medical thinking, we've reduced the vitamin D in our formula from 20 mcg. (800 units) to 10 mcg. (400 units). At the same time, we've increased the vitamin C content from 40 mg. to 50 mg. per tablet and per 5-cc. lemon-candy teaspoonful.

All Other Elements Remain at Their Previous Level.

Vitamin A (3000 units)	0.9 mg.
Thiamine Mononitrate	1.5 mg.
Riboflavin	1.2 mg.
Cobalamin (B_{12})	3 mcg.
Nicotinamide	10 mg.
Pyridoxine Hydrochloride	1 mg.

New Low Price

In quantities of 100 tablets our new Chewable costs less than 4¢ a tablet and the normal dosage is one tablet daily. No financial hardship for your patients when you prescribe or recommend Vi-Daylin.

New Shape, New Color, New Bottle

New Vi-Daylin Chewable tablets are football shaped. This shape got a high degree of acceptance in our taste-tests and seems to have an intrinsic interest for children. The orange color ties in with the mild, sweet citrus flavor. And the wide-mouthed new bottle looks handsome on the table.

Taste-Test New Vi-Daylin Chewable Yourself

Won't you taste-test new Vi-Daylin Chewable multivitamins yourself? We're certain you'll be pleasantly surprised at their sweet good taste. They're the candy-flavored multivitamins with *entrapped flavor* . . . little folks taste the candy flavor, never the vitamins.

ABBOTT

VI-DAYLIN—Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide, Abbott

clinical departments in the College of Medicine were concerned because temporary licensure for residents and interns was not available in Kentucky as in some other states. This matter was discussed recently by the Board of Trustees of the KSMA and referred to the Committee on Legislation.

The proposed program by which the Medical Center would help the State Department of Health in the conduct of diagnostic and referral clinics in pediatrics in various parts of the State was discussed by the Dean. He said such clinics would not be initiated unless they were approved by the local medical societies and would fill a need.

Such clinics, Doctor Willard said, would render a valuable service to physicians and their patients in many parts of the State and would be useful in the teaching program of the College of Medicine. They would also help find patients who might benefit from treatment at the Medical Center.

The Dean said that the Center has secured approximately $1,800,000 in research grants since 1956.

Coal Operators Pass Resolution Opposing H.R. 4222

The National Independent Coal Operators Association, with headquarters at Middlesboro, Ky., February 16 adopted the resolution relating to King-Anderson Legislation which follows:

The Association is made up of 11,300 members in 23 states.

The Journal of the Kentucky State Medical Association is grateful to Mr. Avil McKinney, Louisville, Blue Cross-Blue Shield, for his part in helping to obtain this resolution. Mr. McKinney is temporarily working on a part-time basis with the KSMA and the American Medical Association in the present legislative campaign.

Here is the resolution:

A RESOLUTION

Adopted by the Board of Directors of the National Independent Coal Operators Association, Incorporated, in a special meeting held in Bluefield, West Virginia, on February 16, 1962.

WHEREAS, the United States has the highest standards of health, of medical care, and of scientific facilities of any country in the world, as a result of our system of free enterprise and democratic way of life; and

WHEREAS, these standards will be placed in jeopardy if ever subjected to a federal central control as typified by other nations whose attainments have been lessened by a costly and inert socialistic government; and

WHEREAS, the American people now enjoy the highest standards and comforts of living in the world brought about through their own initiative and personal challenge; and

WHEREAS, any form of socialism which threatens one segment of our American way of life threatens the whole; and

WHEREAS, H.R. 4222 now in the 87th Congress proposes to provide certain medical benefits to a segment of our population through Social Security, thereby imposing extreme tax burdens and national deficits, and promising gradual extension of socialization into other activities of American life, NOW, THEREFORE,

BE IT RESOLVED, that the NATIONAL INDEPENDENT COAL OPERATORS ASSOCIATION, INCORPORATED, does hereby go on record against any form of compulsory health taxation or any system of political medicine designed for national bureaucratic control. That we urge all members of Congress and all coal operators to lend their support to defeating H.R. 4222.

That a copy of this resolution be forwarded to the President of the United States and to each Senator and Representative and that said Senators and Representatives be and hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

Doctor Cole, Illinois Professor, To Address Ky. Surgical Society

Guest speaker Saturday morning, May 26, at the two-day meeting of the Kentucky Surgical Society at the Netherlands-Hilton Hotel, Cincinnati, will be Warren Cole, M.D., Chicago, professor and chairman of the Department of Surgery, School of Medicine, University of Illinois, according to C. Melvin Bernhard, M.D., Louisville, secretary-treasurer of the Society.



Warren Cole, M.D.

Clyde C. Sparks, M.D., Ashland, is Society president and David W. Kinnaird, M.D., Louisville, vice-president.

Doctor Cole is also surgeon-in-chief at the University of Illinois Research and Educational Hospitals and a member of the Board of Scientific Consultants, Sloan-Kettering Institute for Cancer Research. He is a member and past president of a number of medical groups and is known world wide for his development of cholecystography (Graham Cole Test).

He will discuss: Dissemination of Cancer; Adjuvant Therapy for Cancer: Preventive Measures in the Dissemination of Cancer, and Cancer Cells in the Blood Stream.

The meeting will open Friday morning, May 25, with Sessions on that day held in cooperation with the Department of Surgery, Cincinnati General Hospital and the College of Medicine of the University of Cincinnati.

A movie clinic with narration by a member of the surgical team will open the session.

Subjects to be discussed at the morning session by members of the School's faculty are: Report on Studies on the Incidence and Control of Postoperative Wound Infection; Pancreatic Abscess, A Study of 31



Kentucky signs an agreement February 8 with the U. S. Atomic Energy Commission to be the first State to assume duties and responsibilities for licensing, inspection and regulating of nuclear materials. The regulatory authority in the State will be the Division of Radiological health in the State Department of Health.

Pictured at the signing, from left to right: Ed Easterly, press secretary to Governor Bert T. Combs; Leonard T. Kernen, director of industrial development, Kentucky Department of Economic Development; James N. Neel, Jr., coordinator of atomic activities for Kentucky; John Breckinridge, attorney general of Kentucky; Frank L. Chelf, Congressman from the Fourth District; Brent Spence, Fifth District Congressman; Russell E. Teague, M.D., state commissioner of health; John Watts, Sixth District Congressman; Governor Combs; Senator Thruston B. Morton; Carl D. Perkins, Seventh District Congressman; William H. Natcher, Second District Congressman; Frank Stubblefield, First District Congressman.

Cases; Experimental Studies of Staphylococcal Enterocolitis Following Antibiotic Therapy; Studies in the Nature and Control of Infection in Burns; Toxic Factors in Experimental Closed Loop Obstruction; Lymphangiography in Malignant Diseases; Studies in the Incidence of Infection Following Open Chest Cardiac Massage for Cardiac Arrest.

At the Friday afternoon session: Cicatricial Gastric Stenosis; Studies in Incidence and Significance of Postoperative Pneumoperitoneum; Large Breast Tumors in Adolescent Females; Operative Problems in the Surgical Management of Hyperparathyroidism; Experiences with the Surgical Replacement of the Mitral Valve; Wringer Injuries of the Upper Extremity; Clinical Experiences with a Modified Duhamel Operation for Hirschsprung's Disease; Studies in Maintenance of Normal Acid Base Balance During Anesthesia; Studies in Experimental Septic Shock.

Several Papers Featured

The Saturday session of the Society, in addition to the address by Doctor Cole, will feature papers, as follows: "Esophageal Replacement with Reversed Gastric Tube for Bleeding Esophageal Varices in a Four-Year-Old Child," George B. Sanders, M.D., Louisville; "Experiences in Primary Closure of the Common Bile Duct Following Its Exploration," Royce E. Dawson, M.D., Owensboro; "Right Hepatic Lobectomy," David W. Kinnaird, M.D., Louisville; "Peptic Ulcer Surgery in a Rural Community," Charles C. Kissinger, M.D., Henderson; "Duodenal Ulcer Treated by Means of Vagotomy and Pyloroplasty: 15 Years' Experience," Howard E. Dorton, M.D., Lexington; "Lesions of the Right Colon," Coleman C. Johnston, M.D. Lexington; "Resection of a Carotid Body Tumor with Replacement of the Internal Carotid Artery with a Prosthesis," J. Herman Mahaffey, M.D., Louisville.

Friday evening there will be a reception and banquet followed by dancing. Members of the Society are reminded that if they wish to remain in Cincinnati following the close of the session Saturday at 1 p.m., the Zoo is open as an attraction for children and that evening there will be a game between the Cincinnati Reds and the Chicago Cubs.

New Rates For Some AMA Members

The American Medical Association has announced that both dues exempt and associate members are eligible for the 50% subscription rates on AMA periodicals. The move was made to encourage these members to order new subscriptions.

For example, regular rates for the Journal of AMA are $15 for one year and $23 for two, but, under the special 50% rate, subscriptions to these would be $7.50 for one year and $11.50 for two. Similar rates are available to these members on other AMA periodicals.

Doctor Felson To Speak At U. of K.

Benjamin Felson, M.D., Cincinnati, Ohio, will speak at the University of Kentucky Medical Center at 7:30 P.M., May 17, on "Fundamentals of Cardiac Roentgenography." Doctor Felson is professor and chairman of the department of radiology at the University of Cincinnati College of Medicine and Cincinnati General Hospital. He is the author of a recent book, "Fundamentals of Chest Roentgenology," and of numerous papers on radiological subjects, primarily on the heart and lungs.

KSMA Urges Installation of Seat Belts in All Cars

April is safety-belt month in Kentucky, by proclamation of Governor Bert T. Combs, and the Kentucky State Medical Association, along with other interested groups and firms, is promoting their installation in all vehicles.

The Governor pointed out in his proclamation that 87 lives could be saved annually in the Commonwealth if all occupants of cars wore seat belts. This is more than 12% of the yearly highway toll. Glenn Lovern, state commissioner of public safety, said his department has long been aware of the "life-saving potential in the widespread use of safety belts by motorists".

Among groups promoting the month are the Kentucky Junior Chamber of Commerce and the Ashland Oil Company.

The Ashland Oil Company is stocking top quality seat belts ready for installation and at a reduced cost, in every one of its service stations.

The KSMA Highway Safety Committee, headed by Arthur H. Keeney, M.D., Louisville, says that every coupe should have two or three seat belts anchored through the flooring and every sedan, four to six belts, depending on the usual passenger load.

Governor Combs on March 9 signed Senate Bill 30 requiring safety belts on all new passenger cars sold in Kentucky after 1963.

KAGP To Hold Its 11th Scientific Assembly May 9-11

Edgar B. Morgan, M.D., Louisville, president of the Kentucky Academy of General Practice, and Gaithel L. Simpson, M.D., Greenville, president of the Kentucky State Medical Association, will officially welcome guests to the 11th annual scientific assembly of KAGP at the Kentucky Hotel, Louisville, on the opening morning of the session, May 9. The meeting will run through May 11.

Doctor Morgan will preside at the opening day's session. Speakers and their subjects are as follows:

E. D. Pellegrino, M.D., Lexington, Ky.: "Patterns of Functional Disturbances in Renal Disease"; J. Roswell Gallagher, M.D., Boston: "The Medical Care of Adolescents: Part I—The Management of Their Office Visit."

J. W. Worthington, M.D., Rochester, Minn.: "Steroids in Rheumatoid Arthritis"; Ruben H. Flocks, M.D., Iowa City: "The Surgical Management of Urethral Stricture in the Male."

Doctor Pellegrino will also discuss: "Some Aspects of the Use of Quinidine"; Doctor Flocks: "Newer Developments in the Management of Prostatic Carcinoma"; Doctor Worthington: "Newer Developments in Treatment of Gout."

James Sankey Williams, M.D., Nicholasville, KAGP president-elect, will preside at the May 10 session.

Speakers will include: Martin O. Sacks, M.D., Chicago: "Diagnosis of Hemolytic Disease of the Newborn"; George T. Pack, M.D., New York City: "Benign and Malignant Gastric Ulcers"; Edward W. Green, M.D., Detroit: "Problems of Office Diagnosis in Congenital Heart Disease"; Buford Word, M.D., Birmingham, Ala.: "Gynecological Emergencies."



Doctor Pack



Doctor Pellegrino

Doctor Green will also discuss: "The Management of Ventricular Septal Defects"; Doctor Pack: "Soft Part Sarcomas"; Doctor Sacks: "Techniques and Hazards of Exchange Transfusions"; Doctor Word: "Pitfalls of Uterine Curettage."

Doctor Williams will also preside at the May 11 session.

Speakers at this final meeting include: Carl Musehenheim, M.D., New York City: "Chemoprophylaxis in Tuberculosis"; Keith Reemtsma, M.D., New Orleans: "Management of Portal Hypertension." Doctor Musehenheim will also discuss: "Therapeutic Management of Clinical Tuberculosis"; Doctor Reemtsma will speak on: "Current Status of Regional Chemotherapy by Perfusion for Malignant Disease."

The annual banquet and installation of officers will take place Thursday evening, May 10.

Clyde Sparks, M.D., Heads Chapter

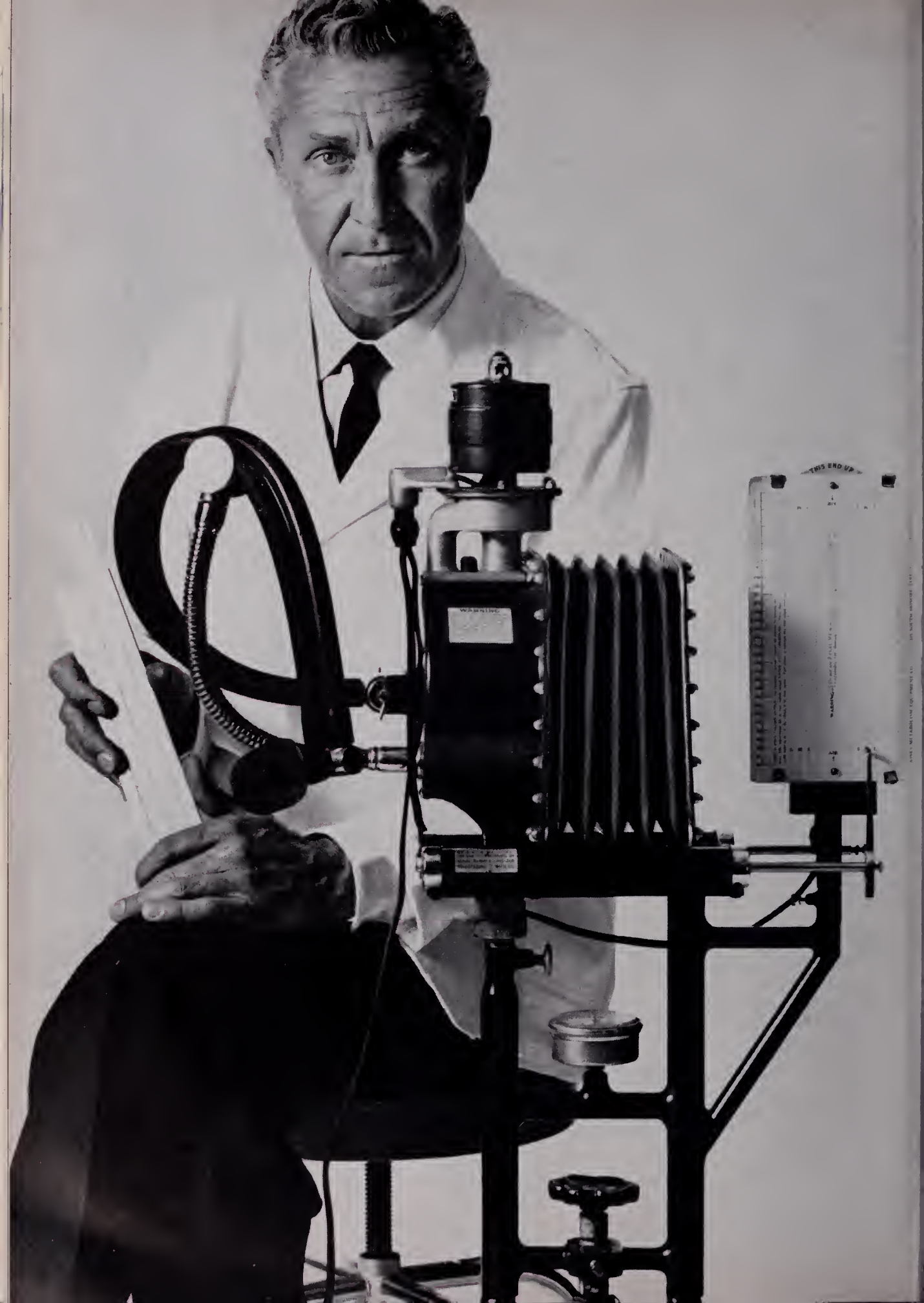
New president of the Kentucky Chapter of the American College of Surgeons is Clyde C. Sparks, M.D., Ashland. Other new officers are: Vice-president, Delmas M. Clardy, M.D., Hopkinsville, and secretary-treasurer, Laurence M. Quill, M.D., Newport.

The new officers were elected at the two-day annual meeting of the Chapter at the University of Kentucky Medical Center, Lexington, March 16-17.

Crutcher Heads Heart Group

Richard R. Crutcher, M.D., Lexington, has been named president of the Kentucky Heart Association to fill the unexpired term of the late Marc J. Reardon, M.D., Covington, who died February 18.

The Kentucky State Medical Assistants Association will hold its first meeting at King's Daughters Hospital, Frankfort, at 2 p.m. April 15. All medical assistants in the State are welcome.


THIS END UP

Can we measure the patient's comfort?

The physician can measure the basal metabolic rate by means of oxygen consumption. But he has no instrument—no objective test—for measuring comfort.

For this, he must depend upon his own powers of observation and the patient's own description of how he feels.

Because these are, admittedly, subjective criteria, the validity of results hinges entirely on the experience and objectivity of the investigators involved.

Such well-qualified clinicians have reported that a new corticosteroid developed in the research laboratories of Upjohn actually raises the level of relief obtainable with this type of therapy.

This difference cannot be "proved." It must be seen. And the only practical way for you to do this is to evaluate this new drug critically in your own practice. Please do, at your first opportunity. We are confident that you will be glad you did.

The new corticosteroid from Upjohn research

Alphadrol®

Each tablet contains Alphadrol (fluprednisolone) 0.75 mg. or 1.5 mg.
Supplied in bottles of 25 and 100.

The anti-inflammatory activity of Alphadrol is comparable to the best effects obtained in current practice. Results obtained with Alphadrol have been such as to warrant classifying it among the most efficient steroids now available.

More than twice as potent as prednisolone, Alphadrol exhibits no new or bizarre side effects. Salt retention, edema or hypertension, potassium loss, anorexia, muscle weakness or muscle wasting, excessive appetite, abdominal cramping, or increased abdominal girth have not been a problem.

Indications and effects

The benefits of Alphadrol (anti-inflammatory, antiallergic, antirheumatic, antileukemic, antihemolytic) are indicated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay fever and allergic disorders, dermatoses, blood dyscrasias, and ocular inflammatory disease involving the posterior segment.

Precautions and contraindications

Patients on Alphadrol will usually experience dramatic relief without developing such possible steroid side effects as gastrointestinal intolerance, weight gain or weight loss, edema, hypertension, acne or emotional imbalance.

As in all corticotherapy, however, there are certain precautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Alphadrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

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February, 1962

The Upjohn Company
Kalamazoo, Michigan

Upjohn

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1962 Annual Meeting — Kentucky State Medical Association

Columbia Auditorium — **Louisville, Kentucky** — **September 18, 19, 20**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman

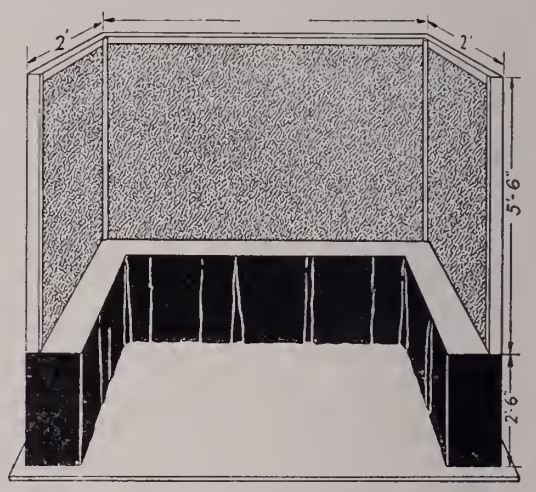
Committee on Scientific Exhibits

Heyburn Building,

Louisville 2, Kentucky

Applications for space should be received before July 1, 1962

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank, not to exceed 100 words, which will be used in the program.)

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Medicine In The Atomic Age To Be AMA Theme

"Medicine in the Atomic Age" will be the theme of the scientific program for the 111th Annual Meeting of the American Medical Association at Chicago, June 24-28. Because Chicago is so easily reached from Kentucky it is expected that a good many members of the Kentucky State Medical Association will attend this meeting.

Site of the meeting, where all scientific and industrial exhibits will be presented and all general and section meetings held, is McCormick Place, the new ultramodern auditorium and convention center, located on the shore of Lake Michigan a short distance south of the Loop.

Air-Conditioned Facilities

McCormick Place is completely air conditioned and is well supplied with restaurants and other facilities to serve the 15,000 to 17,000 physicians expected to register for the meeting.

There will be eight half-day general scientific meetings covering: Inhalation Therapy; Clinical Cardiology and Anticoagulant Therapy; Diagnostic Problems and Exfoliative Cytologic Methods; Tissue Transplantation; Inflammatory and Ulcerative Diseases of the Small Intestine; Teenagers' Problems; Mental Health, and Nuclear Medicine.

In addition, the Multiple Disciplinary Research Forum, which was initiated at the New York meeting last June, will be repeated.

The general meeting on Inhalation Therapy will be sponsored jointly by the American College of Chest Physicians with Kenneth K. Keown, M.D., University of Missouri Medical Center, Columbia, serving as coordinating secretary. The participating sections are: Anesthesiology; Diseases of the Chest; Pathology and Physiology; General Practice, and General Surgery.

The American Heart Association will be co-sponsor of the general meeting on Clinical Cardiology and Anticoagulant Therapy. Wright R. Adams, M.D., Chicago, and Samuel P. Martin, M.D., University of Florida School of Medicine, Gainesville, are the coordinating secretaries. Participating sections: Internal Medicine; Experimental Medicine and Therapeutics; Diseases of the Chest; Pediatrics; General Practice; Preventive Medicine; Orthopedic Surgery, and Pathology and Physiology.

Diagnostic Problems Session

Coordinating secretaries for the general session on Diagnostic Problems and Exfoliative Cytologic Methods are Lemuel C. McGee, M.D., Wilmington, Del., and G. Gordon McHardy, M.D., New Orleans. Participating sections: Preventive Medicine; Gastroenterology and Proctology; Obstetrics and Gynecology; Pathology and Physiology, and General Surgery.

The meeting on Tissue Transplantation is coordinated by John C. Wilson, M.D., Los Angeles. Participating sections are: Orthopedic Surgery; Pathology and Physiology; General Surgery; Internal Medicine; Pediatrics, and Experimental Medicine and Therapeutics.

Session on Nuclear Medicine

The AMA and the Atomic Energy Commission will sponsor the meeting on Nuclear Medicine. Lee Edward Farr, M.D., Brookhaven National Laboratory, Upton, N. Y., is serving as coordinating secretary. Participating sections: Internal Medicine; General Surgery, and Radiology.

Coordinating secretary for the general session on Mental Health will be John E. Adams, M.D., San Francisco. Participating sections: Nervous and Mental Diseases; General Practice, and Internal Medicine.

James L. Dennis, M.D., Oakland, Cal., will be coordinating secretary for the session on Teenagers' Problems. Participating sections: Pediatrics; Nervous and Mental Diseases; Obstetrics and Gynecology; Urology; Dermatology, and Orthopedic Surgery.

Inflammatory and Ulcerative Diseases of the Small Intestine session will be directed by Clyde A. Stevenson, M.D., Spokane, Wash., and G. Gordon McHardy, New Orleans, coordinating secretaries. Participating sections: Radiology; General Surgery; Internal Medicine; Gastroenterology and Proctology, and Pathology and Physiology.

Ky. 1962 Legislative Record As It Affects KSMA Members

During the 60-day legislative session of the Kentucky General Assembly, recently ended, 953 House and Senate bills were introduced of which 92 had medical implication. Forty-four of these passed both houses.

A resume of some of these bills follows:

Senate Bills

S.B. 28—Buckman: Amending KRS 342.020 to include compensation for **chiroproctic** treatment in addition to other treatments under the Workmen's Compensation Act. (Opposed by KSMA.) **Held in committee.**

S.B. 30—McCann: Requiring **safety belt ottochments** on all new passenger cars sold or brought into the state after 1963. (Approved by KSMA.) **Passed and signed by Governor.**

S.B. 46—Ware: Amending KRS 212.640 to add a sixth member, who must be a **dentist,** to the boards of health in counties containing a city of the second class. (Approved by KSMA.) **Passed and signed by Governor.**

S.B. 57—Raney: Amending KRS 402.120 to exempt persons 65 years of age or older from taking a **medicol examinotion** before obtaining a **morriage license.** (Opposed by KSMA.) **A vote was never taken on the bill.**

S.B. 101—McCann: Permitting licensed **physicians** who are members in good standing of state and county medical associations, to **practice in ony hospitol** totally or partially supported by public funds. (Opposed by KSMA.) **Held in Committee.**

S.B. 126—Mann: Amending KRS 161.155 to permit **chiropractors** as well as physicians to certify a teacher's illness under sick leave provisions. (Opposed by KSMA.) **Held in committee.**

S.B. 154—Duffy: Requiring **safety inspections** at least once but not more than twice each year of every **motor vehicle,** trailer and semitrailer registered in Kentucky, by privately owned franchised inspection stations, all vehicles to have been inspected by July 1, 1963; establishing inspection standards providing for supervision by the Department of Public Safety; setting fees for inspections and for licensing of stations; amending KRS 189.730 and 189.990 to conform; repealing KRS 189.740; effective July 1, 1962. (Approved by KSMA.) Passed Senate 22-8; **Defeated in House,** 30-50.

S.B. 220—Mann: Amending sections of KRS Chapter 205 to extend benefits of medical care paid by the Department of Economic Security to include **chiroproctic** services; adding a committee on chiropractic care to the list of technical advisory committees; requiring the addition of a chiropractor to each county medical review committee. (Opposed by KSMA.) **Vote never taken on bill.**

S.B. 223—Swope: requiring parents and guardians to have children **immunized** against diphtheria, smallpox, pertussis, tetanus, and poliomyelitis within 12 months after birth; prohibiting school entry without immunization certificate unless the parent or guardian files a written objection with the governing body of the school. (Opposed by KSMA.) **Held in Committee.**

S.B. 294—Mann: Creating a State Board of **Chiroproctic** Examiners and stipulating qualifications of its members; stating powers, duties, and method of procedure of board; providing traveling expenses and per diem pay for board members; penal-

ties for those practicing chiropractic in violation of provisions of this act; repealing KRS Chapter 312. (Essentially the contents of the bill are the same as compose the present law. KSMA legislative key men were not asked to contact legislators and oppose this bill.) **Passed and signed by Governor.**

House Bills

H.B. 57—Hill, Roberts, Denham, A. E. Tucker, Bunnell, J. Y. Brown: Authorizing creation and incorporation of **professional service associations** by persons required to be licensed to render services; granting to such associations the same power as other corporations; allowing associations to have only one, two or three shareholders; one, two or three directors and one, two or three incorporators who shall be such shareholder(s) and fill all offices; requiring associations having more than three shareholders to have the number of officers and directors required by KRS Chapter 271; allowing the association to render services only through its licensed officers, employes and agents, and to collect fees for such services specifying other requirements for the name of the association, consolidations and mergers, purchases and redemption of shares and certification by the president that all shareholders are licensed; exempting corporations already organized to perform professional services from the provisions of the act. Amended in the House, substituting the words "professional service corporation" for the words "professional service associations"; allowing such corporations to invest funds in real estate, mortgages, stocks, bonds or any other investment, or own property necessary to render such professional services. Amended in Senate, including confidential and ethical relationships in those exempt from alteration by the act; requiring two, instead of one, or more shareholders' names in the corporate name prohibiting any authorization of professional advertising contrary to ethical standards. (Approved by KSMA.) **Passed and signed by Governor.**

H.B. 115—J. Y. Brown: Repealing the tax on individually earned income; earmarking all excess revenue received from the sales tax, over and above the 1962-63 budget, to replace the tax receipts on individually earned income; amending KRS 139.050 to include the price received for labor or services rendered in any business in gross receipts under the sales tax definitions. (Opposed by KSMA.) Amended in House deleting the inclusion of labor and services in gross receipts under the sales tax; graduating earned income exemptions upward annually until all tax on such income is removed, as sales tax revenues increase; requiring lowered exemptions if sales tax revenue declines. **Bill did not pass.**

H.B. 146—Mills: Requiring the Department of Economic Security to promote facilities for **housing care for the aged;** specifying functions of the department as to the provision of assistance and information; establishing a Nursing and Personal Care Home Fund for loans to such projects authorizing transfer of departmental monies to the fund, not to exceed $150,000 for the 1962-64 biennium. (Approved by KSMA.) **Passed and signed by Governor.**

H.B. 236—Denham, Mills: Requiring parents and guardians to have their children **immunized** against diphtheria, smallpox, pertussis, tetanus and poliomyelitis within 12 months after birth; prohibiting entry of a child into school without certificate of such immunization. (KSMA's Bill). **Passed and signed by Governor.**

H.B. 514—Denham: Amending KRS 311.380 to define Board as the State Board of **Podiatry** instead of **Chiropody;** amending KRS 311.410 to name the Commissioner of Health as secretary of the board; amending other sections of KRS Chapter 311 to conform to changes in this act. (Approved by KSMA.) **Passed and signed by Governor.**

H.B. 573—Denham: Prohibiting the advertisement of services by persons licensed to practice **medicine, osteopathy,** or **chiropractic,** except for announcements, telephone directories, and small signs. (Approved by KSMA.) **Bill passed House but failed to get out of Senate Rules Committee.**

House Resolution

H.R. 43—Gaines: Concurrent resolution requesting the **motorcar industry** to incorporate in all American motorcars those devices and structures that are known to be capable of reducing the number of highway deaths and injuries. (Resolution submitted by KSMA Safety Committee.) **Passed and signed by Governor.**

Many other bills of great importance to the medical profession were considered by the Legislature and followed by KSMA during the legislative session such as those concerned with: Regulation of narcotic drugs; use of unclaimed dead bodies for scientific purposes; regulations on information on prescriptions for drugs; regulations on pharmacies; settlement of hospital bills from estates; certificate of ownership for motor vehicles, etc.

If any member desires additional information about legislation passed or considered without passage in the 1962 Legislature, he is urged to contact the KSMA Headquarters Office at 3532 Janet Avenue, Louisville 5, Ky.

Transatlantic Phone Session To Be KSMA Meet Feature

A Transatlantic Telephone Clinicopathological conference on Renal Disease between a group of Louisville physicians and selected British doctors will be a feature of the Annual Meeting of the Kentucky State Medical Association, September 18-20. The time set for this feature is 2 p.m., Wednesday, September 19.

The Annual Meeting will be held at the Columbia Auditorium, Louisville, where these annual sessions have been held each year since 1950. During the session there will be 14 specialty groups holding conferences. Half of these will meet Tuesday afternoon, September 18, and half on Thursday, September 20.

The Transatlantic Conference is sponsored by Smith, Kline & French, Philadelphia.

Post Office Asks Physicians To Cooperate on Plan

The Post Office Department is asking doctors to cooperate in its Nationwide Improved Mail Service program, inaugurated several months ago in an effort to ease the late evening avalanche of mail and spread the work of the post office throughout the entire day. The Headquarters Office of the Kentucky State Medical Association is cooperating with this program.

Physicians are asked to consider mailing statements on an alphabetical basis during the month, if possible, and to schedule mailing of statements in the morning and early afternoon hours.

Early mailing, according to the post office, means a smoother, more efficient operation in the department thus providing better service to the mailer because of less rush and fewer mistakes and more mail dispatched on time.

Speakers at Interim Meeting Cover Wide Range of Subjects

A wide range of topics of immediate and particular interest to the medical profession was discussed by an array of outstanding speakers at the Interim Meeting of the Kentucky State Medical Association at Gabe's Restaurant, Owensboro, February 22.

The morning session was presided over by Gaithel L. Simpson, Greenville, KSMA president. Guests were welcomed to the meeting by William J. Oldham, M.D., Owensboro, president of the Daviess County Medical Society.

"How Private Practice Can Survive" was the topic of Carl R. Ackerman, M.D., director, United Medical Service, Inc., New York City and vice-chairman of the Board of Directors of the National Association of Blue Shield Plans. Doctor Ackerman emphasized the importance of making voluntary medical plans work and telling the public that the medical profession can provide the means for securing reasonably priced voluntary medical care.

Austin Smith, M.D., Washington, D. C., president of the Pharmaceutical Manufacturers Association, discussed in detail the Kefauver hearings on drug prices



At the Interim Meeting of the Kentucky State Medical Association at Owensboro, February 22: Seated, left to right, Wyatt Norvell, M.D., New Castle, chairman of the Board of Trustees; Austin Smith, M.D., Washington, D. C., president, Pharmaceutical Manufacturers Association and one of the featured speakers; the Rev. Robert P. Varley, Salisbury, Md., another speaker; Carl R. Ackerman, M.D., New York City, director, United Medical Service, speaker. Standing, left to right, William J. Oldham, M.D., Owensboro, president of the Daviess County Medical Society; David M. Cox, M.D., Louisville, KSMA president-elect; Gaithel L. Simpson, M.D., Greenville, KSMA president; William McBeath, M.D., Frankfort, acting director, Division of Medical Care, State Department of Health, another speaker.

and stressed the need for mutual cooperation between medicine and allied professions in stemming the tide against socialism.

Wesley W. Hall, M.D., Reno, Nev., member of the Board of Trustees of the American Medical Association, was a scheduled speaker but unable to attend the meeting because of bad weather which interrupted plane service.

William H. McBeath, M.D., Frankfort, acting director, Division of Medical Care, Kentucky Department of Health, outlined the operation of the Kerr-Mills program in Kentucky.

Luncheon speaker was the Rev. Robert P. Varley, rector of St. Peter's Episcopal Church, Salisbury, Md.

David M. Cox, M.D., Louisville, KSMA president-elect, presided at the afternoon session which featured an address by William R. DeMougeot, Denton, Tex., director of debate and forensics and professor of speech at North Texas State University. He said, in discussing the threat of socialized medicine, that there are things doctors can and want to do to combat this trend.

Discussion concluded the program.

Pathologists To Meet April 21

The Kentucky Society of Pathologists will hold its regular meeting at 2 p.m. April 21 at the Academy of Medicine, Cincinnati, according to George R. Tanner, M.D., Ft. Thomas, secretary-treasurer of the Society. A seminar on pulmonary pathology will be presented by R. J. Ritterhoff, M.D., pathologist at St. Elizabeth Hospital, Covington.

The regular February meeting of the Society was held at the Sheraton Hotel, Louisville, February 10. Daniel Stowens, M.D., Children's Hospital, Louisville, presented a paper on leukemia.

Annual Postgraduate Pediatrics Course April 10-May 29

The annual Postgraduate Course in Pediatrics is being conducted at Children's Hospital, Louisville, Ky., April 10 through May 29. The course is presented by the Department of Pediatrics of the University of Louisville School of Medicine and is sponsored by the Kentucky Chapter of the American Academy of Pediatrics, the Kentucky Academy of General Practice and the Office of Postgraduate Medical Education of the Kentucky State Medical Association.

The faculty is composed of professors and instructors from the U. of L. School of Medicine.

Those attending the course meet each Tuesday morning, beginning April 10, in the Children's Hospital Amphitheatre. Ward rounds are followed by lectures and discussions. Some of the topics under discussion: "Histoplasmosis"; "Surgical Emergencies in Newborn Infants"; "Clinical Application of Growth Problems"; "Complications and Recent Advances in Treatment of Measles and Mumps"; "Renal Infections in Children"; "Caustic Burns of the Esophagus in Children"; "Brain Injured Child"; "Leukemia in Children."

Tuition fee for the entire course is $25 or $4 for each session. The course has been approved by the AAGP for 27 hours of Category 1 Credit.

James M. Fraser, M.D., has begun general practice at Jenkins, Ky. Doctor Fraser was graduated from George Washington University Medical School in 1939. He was formerly with the Frontier Nursing Service at Hyden, Ky., from 1943 to 1945 and also practiced at Tomah, Wis., and Grand Lake, Col., before going to Jenkins.

OPPORTUNITIES

From The

KSMA Postgraduate Medical Education Office

Gift to Postgraduate Office

Hoffman-La Roche, Inc., Nutley, N. J., has made a grant to the Postgraduate Medical Education Office of the Kentucky State Medical Association for $500 to support the postgraduate education program.

On November 29, 1961, the Kentucky Postgraduate Medical Education Fund was ruled exempt from the federal income tax and contributions to the fund are deductible by the donor. Gifts or transfers to the Office are deductible for federal estate and gift tax purposes.

In Kentucky

APRIL

10 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

17 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

18-20 Kentucky Tuberculosis Association, Louisville, Ky.

18-19 Kentucky Pediatric Society, Frankfort, Ky.

24 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

25 Kentucky Psychiatric Association, Semi-Annual Meeting, Lexington, Ky.

MAY

1 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

8 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

9-11 KAGP Annual Scientific Meeting, Louisville, Ky.

15 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

17 Benjamin Felson, M.D., "Fundamentals of Cardiac Roentgenography," University of Kentucky Medical Center, Lexington, Ky., 7:30 p.m.

17-18 Kentucky Obstetrical & Gynecologic Society, Owensboro, Ky.

22 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

29 **Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

JUNE

7 KAGP Seminar, Harrodsburg, Ky.

14 KAGP Seminar, Henderson, Ky.

Surrounding States

APRIL

23-28 American Academy of Neurology, New York, N. Y.

25 Postgraduate Course, **Dermatology,** University of Tennessee College of Medicine, Memphis, Tenn.

30-May 2 American Academy of Pediatrics Spring Session, New York, N. Y.

MAY

2-4 Postgraduate Course, **Orthopedics,** University of Tennessee College of Medicine, Memphis, Tenn.

7-11 American Psychiatric Association, Toronto, Ont., Canada.

10-11 American Pediatric Society, Atlantic City, N. J.

14-17 American Urological Association, Philadelphia, Pa.

20-25 National Tuberculosis Association, Miami, Fla.

23-25 Postgraduate Course, **Psychiatry,** University of Tennessee College of Medicine, Memphis, Tenn.

24 Postgraduate Course, **Inter-Relationships of the Mental Hospital and the Psychiatric Problems of Medical Practice,** Vanderbilt University School of Medicine, Nashville, Tenn.

28-June 2 American College of Radiology, Denver, Col.

28-30 American Ophthalmological Society, Hot Springs, Va.

31-June 2 American Gynecological Society, Hot Springs, Va.



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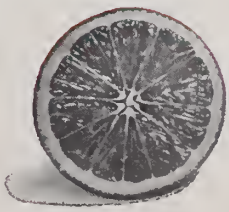
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Southeastern Surgical Congress Elects New Officers

Harwell Wilson, M.D., Memphis, Tenn., was installed as president of the Southeastern Surgical Congress at its 30th annual assembly at the Brown Hotel, Louisville, March 5-8. Doctor Wilson is professor of surgery and chief of the Department of Surgery at the University of Tennessee Medical College at Memphis.

Joseph D. Martin, Jr., M.D., professor and head of the Department of Surgery at Emory University, Atlanta, Ga., is the new president-elect of the Congress.

Other new officers are: first vice-president, Howard Bradshaw, M.D., Winston-Salem, N. C.; second vice-president, Hu Myers, M.D., Philippi, W. Va.; counselor, Jack Emmett, Clifton Forge, Va.

J. Alex Haller, Jr., M.D., Louisville, received the President's Medal for the best research paper on surgical experiments presented during the Congress. Doctor Haller, who is assistant professor of surgery at the University of Louisville School of Medicine, discussed, "Studies on Iliofemoral Venous Thrombosis."

Due to inclement weather two speakers from the East who were scheduled to address the Congress were unable to keep their speaking engagements. Two Louisville physicians, who substituted for them on the program and gave excellent papers, were: Joseph E. Hamilton, M.D., chief of surgery, Veterans Administration Hospital, and Richard C. McPherson, M.D., University of Louisville School of Medicine.

The Congress picked the Americana Hotel, Miami Beach, Fla., for the 1963 meeting.

Blue Cross-Blue Shield Reports for '61

The 1961 report of Kentucky Blue Cross-Blue Shield indicates that there are 80,000 persons aged 65 or over enrolled in the plans in the State. There are more than 5,000,000 in the country in this age group enrolled in Blue Cross-Blue Shield plans.

Kentucky statistics are as follows:

Blue Cross

Number of hospital cases	114,689
Number of days' care	701,921
Blue Cross paid	$18,285,019.96
	(93% of income)
Operating costs	4.45%
Membership	822,789

Blue Shield

Number of services rendered	208,531
Blue Shield paid	$6,766,410.93
	(86.32% of income)
Operating costs	9.89%
Membership	739,936

C. F. Sullivan, M.D., Paducah, has been named a member of the board of trustees of the Paducah-McCracken County Heart Association.

Public Health Survey Units To Be At Louisville in April

This month the U. S. National Health Survey will set up its mobile units in the Louisville area and will interview 150 families. Purpose of the survey, conducted by the U. S. Department of Health, Education and Welfare, is to collect data from a representative sampling of the U. S. civilian, noninstitutional population.

The Survey has two mobile examination centers which are moved from area to area across the nation. The examining staff consists of two physicians, one dentist, two nurses, two receptionist-interviewers and two laboratory x-ray technicians.

Findings of each examination are not given to the person being examined but may be sent to a physician or dentist of his choice if he wishes. Each examination requires about two hours.

Fifty grams of glucose are given to examinees with no history of diabetes. Medical history is obtained. X-rays are taken of hands, feet and chest. Pregnant women are not x-rayed. Weight and height are taken and the air conduction threshold measured in a soundproof booth.

A physical examination stressing cardiovascular disease and arthritis is given; three blood pressures on the left arm in sitting position; blood samples are taken for determination of blood glucose, serum cholesterol, serum bentonite flocculation test, serologic tests for syphilis and microhematocrit.

Certain body measurements are made. An electrocardiogram is taken, also urine specimen is tested for albumin (males only) and for glucose; dental examination is made; visual acuity, screening test for near and far vision without glasses and with glasses if used.

The 150 homes whose occupants will be tested are scientifically selected in the Louisville area. The findings obtained are used purely for statistical purposes.

Medical Schools Receive Checks From AMA Foundation

The University of Kentucky Medical Center and the University of Louisville School of Medicine received checks from the American Medical Association Education and Research Foundation during the Interim Meeting of the Kentucky State Medical Association at Owensboro, February 22.

The checks were presented to William R. Willard, M.D., dean of the U. of K. Medical Center, Lexington, and J. Murray Kinsman, M.D., dean of the U. of L. School of Medicine by Wyatt Norvell, M.D., New Castle, chairman of the KSMA Board of Trustees. The U. of K. received $2,118.20 and the U. of L. $9,697.57.

Doctor Norvell, in making the presentation, said the U. of K. check was based on its classification as a two-year medical school and that next year a larger amount would be given when U. of K. qualifies as a four-year medical school. (See picture on page 409.)



Wyatt Norvell, M.D., (right) New Castle, chairman of the Board of Trustees of the Kentucky State Medical Association, is shown presenting checks from the American Medical Association Education and Research Foundation to, left to right, William R. Willard, M.D., Lexington, dean of the University of Kentucky Medical Center, and to J. Murray Kinsman, M.D., dean of the School of Medicine of the University of Louisville. The presentation was made at the KSMA Interim Meeting at Owensboro, February 22. (See story on page 408.)

Ky. Ob-Gyn Group Plans Meeting in Owensboro, May 24-26

Tentative plans for the annual spring meeting of the Kentucky Obstetrical and Gynecologic Society call for both nationally known and local speakers to participate in the scientific program at Gabe's Restaurant on May 24, 25 and 26, according to William H. Parker, M.D., Owensboro, president of the group.

The three-day program will include a banquet and social hour as well as the scientific talks and exhibits by pharmaceutical companies.

In making the announcement of the meeting, Doctor Parker urged all members of the group to make an effort to attend as he said, "This meeting should be outstanding in both scientific excellence and in the opportunity it will afford to get together with other practitioners in the ob-gyn. field."

KSMA Reports New Members

The following new members have been reported by the Kentucky State Medical Association: Douglas LeNeave, M.D., Louisville; George T. Donovan, M.D., Erlanger; Roy J. Moser, M.D., and Robert E. Hemmer M.D., both of Covington.

Also: James A. Baumgarten, M.D., Owensboro; H. W. Conran, M.D., Hopkinsville, and Andrew P. Nelson, M.D., Fulton.

U. of L. Seniors in "Who's Who"

Four seniors at the University of Louisville School of Medicine have been named to "Who's Who Among Students in American Colleges and Universities." They were chosen for inclusion in the publication this year on the basis of scholarship, activities, and leadership. They are: Barney E. Elliott, Jr., Bernard D. Greenwell, Olson Huff, and Anna M. McHargue.

Student AMA

University of Louisville

Student Association To Meet

The national convention of the Student American Medical Association is to be held in Washington, D.C., May 9-12. As a prelude to this meeting, Region Four (of which Louisville is a member) met at Ohio State University at the end of March. One of the items discussed at the regional conference and to be discussed at the national meeting, and one which has been discussed repeatedly, is the changing of the name of the Student AMA.

It is exactly for that reason — Student AMA — that every year someone injects a resolution to change SAMA's name, based on the idea that the name implies that the student group is simply an arm of the AMA.

We at Louisville feel that this is insufficient reason to bog down convention proceedings and necessitate lengthy discussion as is the case each year. The Student AMA is autonomous and separate from the AMA and its policies — a fact well known to all SAMA members.

The proceedings of the convention are concerned with problems peculiar to medical students, and the Student AMA is officered and run by medical students and their representatives. It is a well knit organization seeking to improve medical education and to increase the amount of communication between different medical schools.

To change the name of the organization would make it no more nor less effective in carrying out the functions which the constitution outlines and its



A portion of the study cubicle area at the University of Kentucky Medical Center, Lexington (The Journal, March 1962, p. 292). Shown here are, left to right, Medical Students James Roy Biggs, Jr., James McGowan and Ballard D. Wright.

members perform. Rather, it would seem that changing the name because it is closely akin to the name of the AMA would indicate doubt on the part of SAMA's members as to their eventual role in the latter group.

We feel that this issue which comes up so repeatedly is mainly an attempt on the part of many groups "to be heard" and as such has little valid support. We feel the name of the organization which serves medical students nationally is altogether sound and fitting.

As the AMA is to the physician, just so is the Student AMA to the medical student.

Olson Huff, President
University of Louisville SAMA

Rural Health Conference Slated For Des Moines May 18-19

The Council on Rural Health of the American Medical Association has announced plans for the Midwestern States Third Regional Rural Health Conference to be held May 18-19 at the Hotel Savery, Des Moines, Iowa.

Program topics include: "What We Should Know About Health Insurance," "Gimmicks and Gadgets of Medical Quacks," "Animal Diseases and Human Health," "Disaster Medical Care—Medical Self-Help Training Program," "Effective Community Cooperation in a Medical Scholarship and Loan Fund Program."

There will be audience participation in each session of the conference.

William B. Atkinson Dead

William B. Atkinson, Ph.D., 44, chairman of the anatomy department of the University of Louisville School of Medicine, was found dead in his office at the School March 4. His death was ruled suicide by poisoning. The coroner's verdict said Doctor Atkinson swallowed potassium cyanide.

Doctor Atkinson had headed the U. of L. anatomy department since 1958 and before that was associate professor of anatomy at the University of Cincinnati College of Medicine. He was an ordained priest of the Episcopal Church. During the past several summers he had done cancer research at the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Me.

John A. Koepke, M.D., has joined the staff of the University of Kentucky Medical Center. He limits his practice to clinical pathology. A 1956 graduate of the University of Wisconsin School of Medicine, Doctor Koepke took his internship and residency training at Milwaukee Hospital.

Another new member of the University of Kentucky Medical Center staff is **John H. Githens, M.D.**, appointed professor of pediatrics. Doctor Githens received his medical degree from Temple University in 1945 and interned at Abington Memorial Hospital. He took residency training at Philadelphia Children's Hospital and Colorado General Hospital. He served two years with the U.S. Navy, and has had a private practice in Denver from 1951-52 and a full time academic appointment in Denver from 1952-60.

KSMA Legal Services For Members Explained

The Kentucky State Medical Association House of Delegates at its 1961 fall meeting asked that the 1960 statement of the Board of Trustees with regard to the circumstances under which services of the KSMA's legal counsel would be offered free to its members should again be called to the attention of the entire membership.

The 1960 statement follows:

"The Executive Committee of the Board of Trustees of KSMA is glad that our legal counsel is conversant with the statutes and interpretative court decisions as they relate to the practice of medicine in Kentucky and that he is available to you.

"The Association's attorney, Mr. E. Gaines Davis, Jr., P.O. Box 404, Frankfort, is employed to take care of the legal affairs of the Association. When he is approached by an individual or county society, the question sometimes arises as to who is to pay for the requested legal services.

"Does the question you have relate to a matter which directly affects the Association itself, or is it a matter of primarily local or private concern? The following may help you find an answer.

"Naturally, any problem which concerns physicians is one of general interest to the Association. But since several county societies have their own retained counsel, it would not be fair for the Association to furnish counsel to those who do not, with respect to matters in which it has no direct interest. Chances are that in most cases you will know whether your question meets the above-stated test. In case of doubt, you may submit your question to Mr. Davis with the understanding that, if the Executive Committee decides that it does not affect the Association directly, you or your county society will be responsible for his fee."

Tuberculosis Meet April 26-27

The joint annual meetings of the Kentucky Tuberculosis Association and the Kentucky Thoracic Society will be held April 26-27 at the Sheraton-Seelbach Hotel, Louisville. Progress toward tuberculosis eradication and discussions of research and respiratory disease will be featured.

Two of the speakers will be Harry Walkup, M.D., director of research for the National Tuberculosis Association, and Jerry Cohn, M.D., University of Kentucky Medical School, Lexington.

Radiologists' Society Elects

The Kentucky Society of Radiologists at their January meeting elected the following officers: President, Edward N. Maxwell, M.D.; president-elect, James B. Douglas; secretary-treasurer, Lawrence A. Davis, M.D. All are from Louisville.

William J. Hanley, M.D., has opened an office for general practice in Owensboro. Doctor Hanley is a 1958 graduate of the School of Medicine of the University of Louisville. He previously practiced at Beaver Dam, Ky.

Blue Shield Pays Out Record Sum

More than $613,600,000 was paid out by the 75 Blue Shield plans of North America for surgical-medical care to members during the first nine months of 1961, according to John W. Castellucci, executive vice president of the National Association of Blue Shield Plans. This figure represented an all-time high for a nine-month period, exceeding the 1960 figure for a comparable period by more than $62,000,000.

"The record payment represented more than 90% of the total income of these medical-surgical plans," Mr. Castellucci reported. Meanwhile the plans spent less than 10% of their total income during the period for administrative expenses.

Grant Made to Doctor Pirkle

The Medical Advisory Board of the National Hemophilia Foundation has approved a research grant to H. C. Pirkle, M.D., associate professor, Department of Pathology, School of Medicine, University of Louisville. The grant is for electron microscopic investigation of the role of blood platelets in thromboplastin formation.

Baldwin Goes to Indianapolis

George Baldwin has resigned as administrator of the Louisville Marine Hospital to become chief of Medico Environs, Inc., Indianapolis, a private progressive-care type hospital, being developed by a group of physicians and others.

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County Society Reports

McCracken County

A committee to solicit and collect membership fees in KEMPAC and AMPAC was named by J. Vernon Pace, M.D., president, at the February 28 meeting of the McCracken County Medical Society. Warren E. Sloan, M.D., was named chairman.

The Society's insurance committee, headed by C. P. Orr, M.D., was requested to study and report on the service contract recommended by the American Medical Association Board of Trustees and the national Blue Shield board.

Wendell E. Gordon, M.D., has opened an office for general practice at Benton, Ky. Doctor Gordon was graduated from the University of Tennessee College of Medicine, Memphis, in 1959. He served his internship at St. Joseph's Hospital in Memphis, Tenn., and previously practiced at Paragold, Ark.

Edward C. Bowling, M.D., a surgeon in Lebanon since 1957, has been awarded a fellowship in surgery of the colon and rectum at the Mayo Clinic, Rochester, Minn. He will begin two years of study at the clinic on July 1. Before coming to Lebanon where he was associated with **B. J. Baute, M.D.,** he was chief resident in general surgery at Veterans Administration Hospital, Louisville. Dr. Bowling is a graduate of the University of Louisville School of Medicine in 1952. Upon completion of his fellowship, he will be qualified as a proctologist.

EENT Meet in April at Greenbrier

The West Virginia Academy of Ophthalmology and Otolaryngology's annual meeting, featuring four prominent guest speakers, will be held at the Greenbrier Hotel, White Sulphur Springs, West Va., April 23, 24, and 25.

Those on the program will be Ramon Castroviejo, M.D., New York, N. Y., and Frank D. Costenbader, M.D., Washington, D. C., ophthalmology; and Kelvin A. Kasper, M.D., Philadelphia, Pa., and Fred R. Builford, M.D., otolaryngology. A registration fee of $25 for associate members will cover all social and scientific sessions. For additional information, contact the secretary, Worthy W. McKinney, M.D., 109 East Main St., Beckley, West Va.

Meriwether Gets New Post

Richard E. Meriwether, who has been on the staff at Western State Hospital, Hopkinsville, since May 1955, has been named director of hospital administration for the Kentucky Department of Mental Health. He joined the Department's central office staff at Louisville February 1, succeeding T. H. Lewis, who resigned.

W. F. Chumley, M.D., who has been serving in the Navy for several months, has returned to resume his practice at Beaver Dam. Doctor Chumley graduated from the University of Louisville School of Medicine in 1956.

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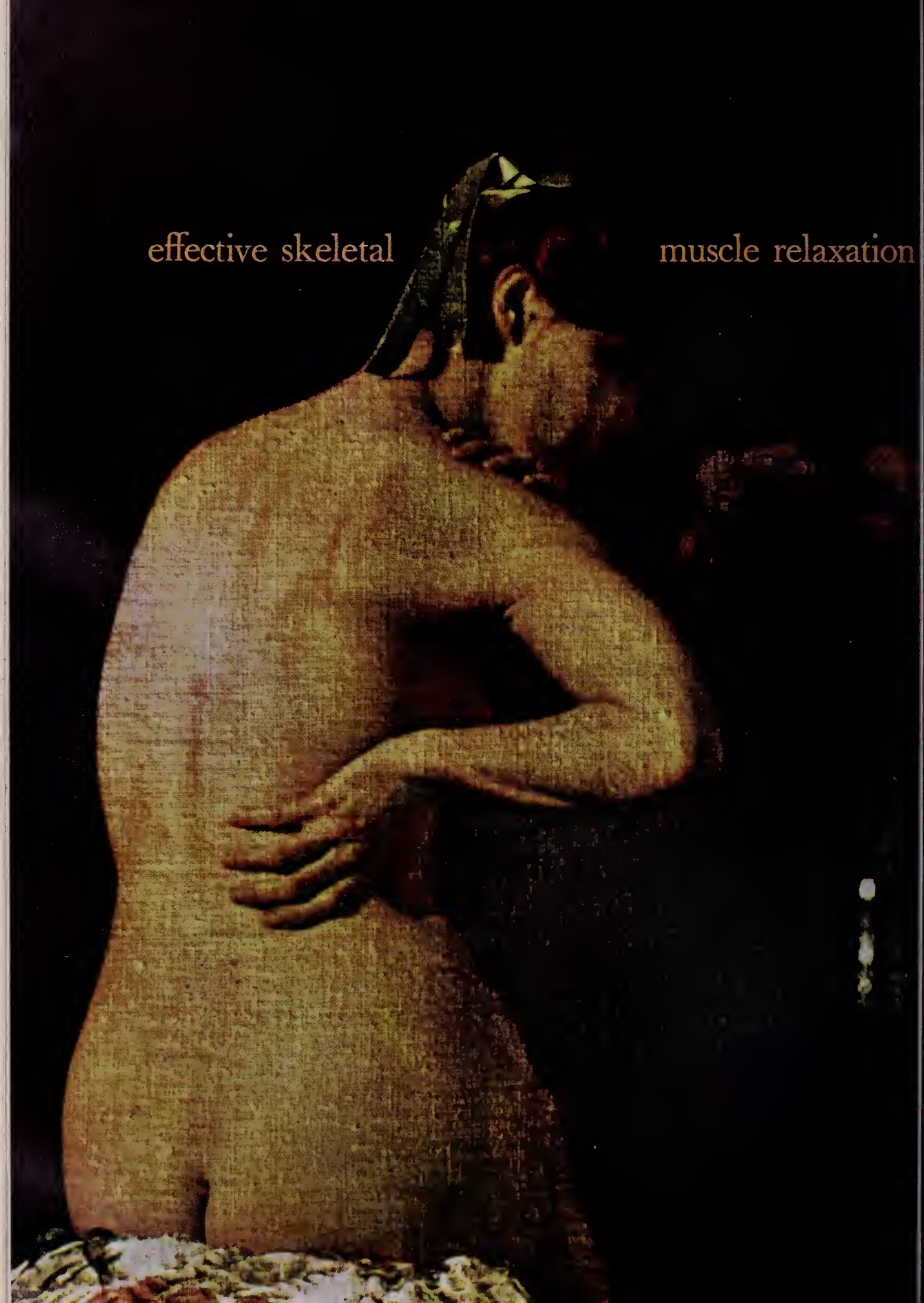
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Methocarbamol (Robins)	400 mg.	Acetylsalicylic acid (1¼ gr.)	81 mg.
Phenacetin	97 mg.	Hyoscyamine sulfate	0.016 mg.
		Phenobarbital (⅛ gr.)	8.1 mg.

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References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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"...remarkably effective..."[2]

"...a high potential for prompt relief..."[8]

"...unusual freedom from toxicity..."[1]

Money for Mental Health Needed

H. L. McPheeters, M.D., Kentucky's mental health commissioner, expressed hope that increased funds from the federal government would be made available to meet the state's growing costs of mental health programs. He stated that presently the department is completely dependent upon appropriations from the General Assembly.

His annual report to Governor Combs, covering July 1, 1960—June 30, 1961, stated that Kentucky's expenditures for mental health are still below the national average. Among the year's accomplishments were establishment of rehabilitation units at three hospitals and the expansion of a unit at the fourth, introduction of ward activity programs at all of the hospitals, additional out-patient and follow-up services, and the announcement that salaries of departmental psychiatrists would be raised above statutory limitation.

Library Seeks Reprints

Because of extensive losses suffered in a fire, the research library of the Institute of Experimental Medicine and Surgery of the University of Montreal, Canada, is asking readers of The Journal of the Kentucky State Medical Association to send to it all available reprints of their work, especially those dealing with endocrinology and stress. Since its mailing list was destroyed also, the Institute reports it can send reprints of its own publications only to those who write for them.

The address is: Institute of Experimental Medicine and Surgery, University of Montreal, P.O. Box 6128, Montreal 26, Canada.

Washington Medical Sessions

Several medical meetings will be taking place in Seattle and elsewhere in the State of Washington during the time of the Seattle World's Fair April 21 to October 21, 1962. The 73rd annual meeting of the Washington State Medical Association will be at Spokane, September 16-19.

Other scientific meetings to be held during this period will cover such subjects as: Allergy, anesthesiology, general practice, internal medicine, neurology, obstetrics and gynecology, ophthalmology, pediatrics, radiology, surgery and tuberculosis.

The 61st annual meeting of the Medical Library Association will be held at Chicago June 4-8 at the Sheraton-Chicago Hotel. Chairman of exhibits is Charles Hughes, Library of Medical Sciences, University of Illinois, and convention chairman is Donald Washburn, D.D.S., American Dental Association—both of Chicago.

According to the Institute of Life Insurance there were 7,600 ordinary life insurance death payments in 1961 for a total amount of $21,000,000. Group claims totaled 5,400 with total payments of $11,400,000; industrial, 20,000 for $6,000,000. The total of all death payments for the State was 33,000 for a sum of $38,400,000.

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Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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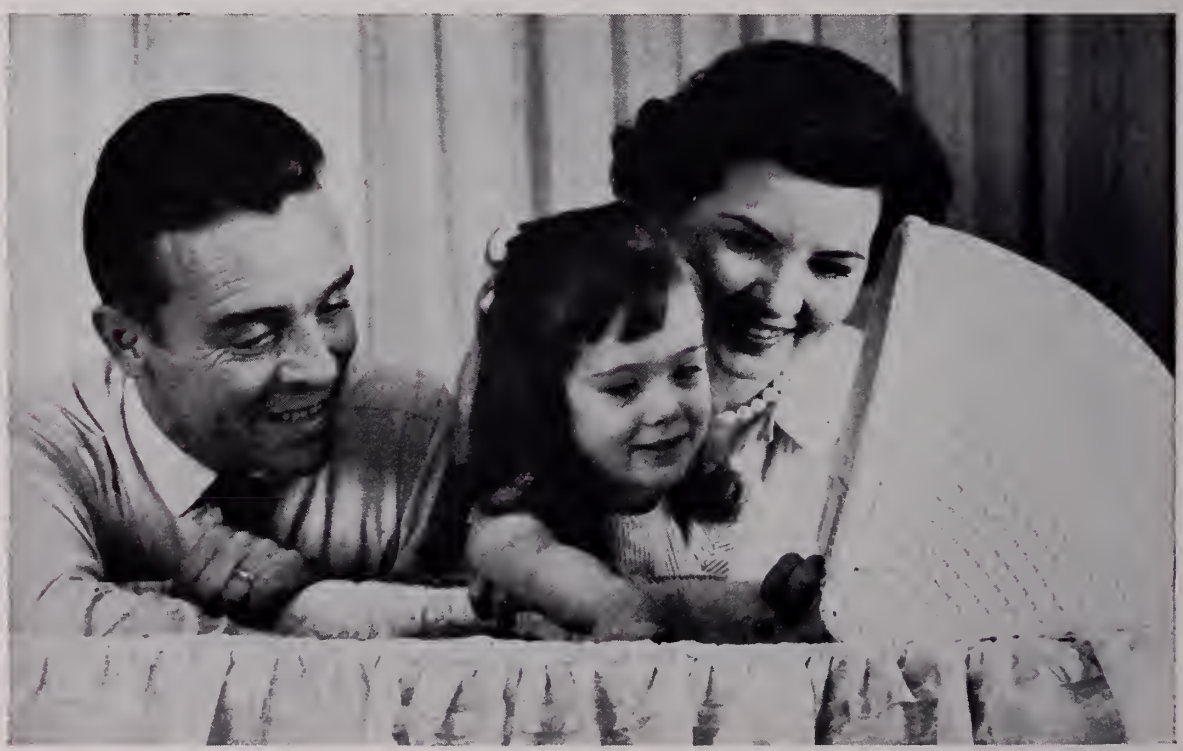
The new baby is beautiful, but his arrival raises some problems in family planning on which the mother will need help — *your* help. What you counsel or suggest to her may determine the family's happiness for many years to come. When she comes in to see you for her routine postnatal check-up, you have an ideal opportunity to counsel her and answer her questions. It's also an ideal time to recommend the use of Lanesta Gel.

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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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IN THE BOOKS



CLINICAL OBSTETRICS: by Benjamin Tenney, M.D., and Brian Little, M.D., F.R.C.S. (C); published by W. B. Saunders Company, Philadelphia and London; 440 pages; price, $8.50.

Doctors Benjamin Tenney and Brian Little show their conservative idea of practicing obstetrics at Boston City Hospital in their new textbook, Clinical Obstetrics.

It is an excellent review of obstetrics for the interne, resident and practicing physician. It consists of 424 pages with 24 chapters, each of which is subdivided into several important and pertinent subtopics. Also, there is a complete 16-page index.

There is very little material on actual delivery technique, but the explanations with 44 illustrations are adequate. The subtopics are well placed, stress their importance and make reading effortless.

The chapter on prolonged labor and its many pitfalls is specific in determining reasons for, and conservative management of, this frequent problem. The approach to induction of labor is practical. The pitocin drip, when properly used, is praised as an aid to good obstetrics.

Ruptured membranes, chorioamnionitis and the effect on fetus and mother are discussed at length.

In the entire volume there are only discussions and advances which have demonstrated clinical value. The book is pleasantly unlike the usual textbook and is one which may be read from cover to cover because of the well presented cases, new approaches and changing emphasis on old problems.

I enjoyed reading of the practice of obstetrics in Boston.

Edward E. Bell, M.D.

PROBLEMS IN SURGERY: Frank Glenn, M.D.; edited by George E. Wantz, Jr., M.D.; published by C. V. Mosby Company, St. Louis, Mo.; 512 pages; price $16.50.

Within 496 pages the editors of this book have tried to compress the case histories and discussion of 152 cases presented at the Surgical Grand Rounds of the Cornell New York Hospital. This leaves only three or four pages per case which turns out in most instances to be woefully inadequate, particularly since the majority of the cases are illustrated. Some are uncomplicated typical examples of a given condition. As one might suspect, given the space limitations, these turn out to be the more successful presentations for this type of book. The moderator generally introduces discussion by asking one of the experts, "Now what is the correct status of our therapy for this condition?" and the final two pages give an answer in summary form. As such, this book furnishes a handy albeit spotty means of checking up on "What's New."

Discussion of the more complex cases is so obviously superficial that many of these discussions are almost worthless. A few surgical pearls and some very good x-ray reproductions are available however.

It is difficult to assign a niche for this book. It is too superficial as a text and too expensive as a year book for keeping up to date. It may be of some value to the generalist who wants to know the current thinking in one of our better surgical centers. If only one-fourth to one-third of the cases had been presented I feel it would have been far better, and space would have been available for a discussion in depth of some of the interesting cases.

The book is attractively bound, printed and illustrated. Editing the tape recordings of these sessions must have been a Herculean task and was well done. References and indices are very good, but, alas, a book of this kind loses much by its inability to be exhaustive in so many fields and by the obvious superficiality of its coverage of any one subject.

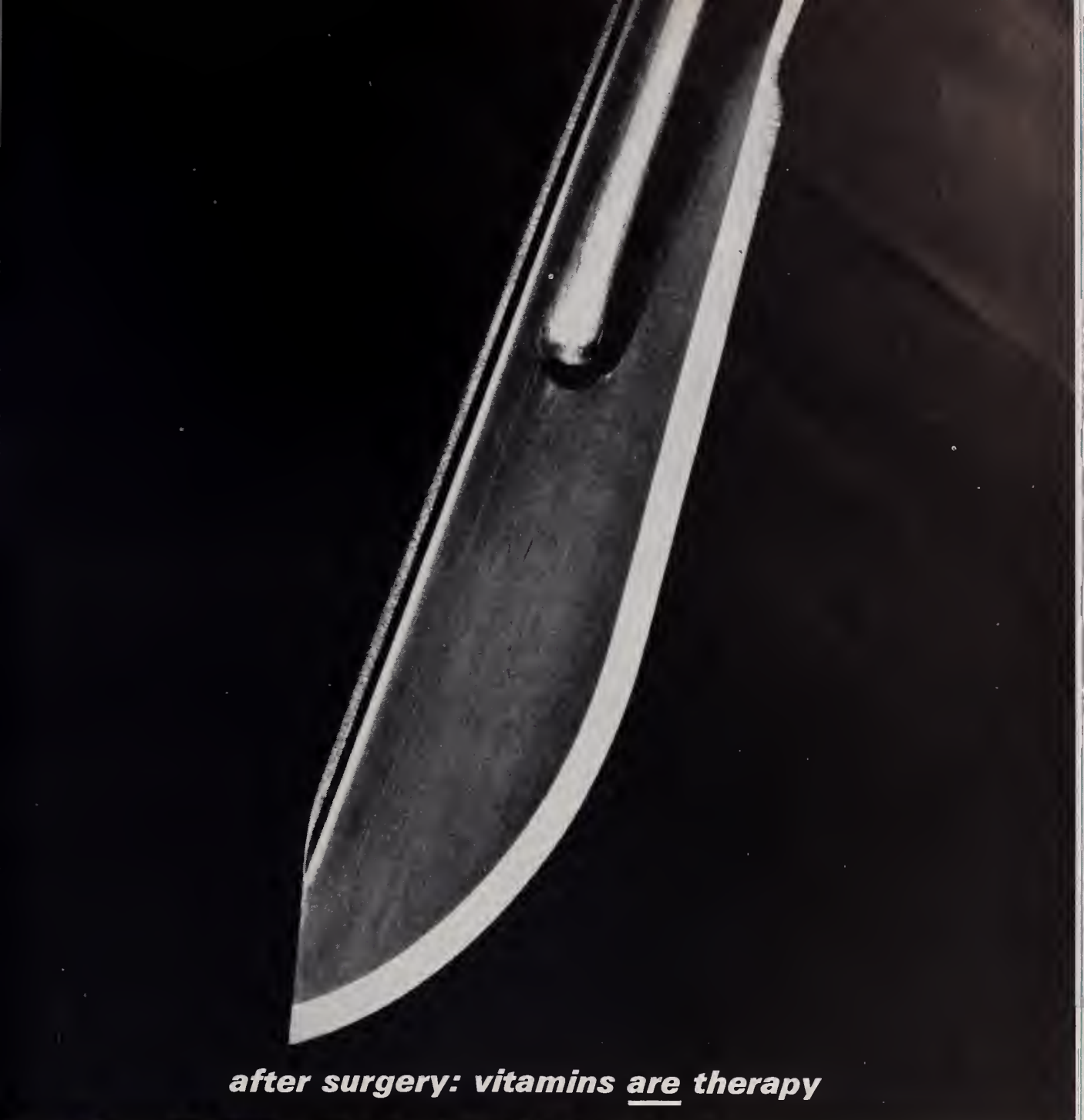
Ben Eiseman, M.D.

W. B. Saunders Company features the following recent books in their full page advertisement appearing elsewhere in this issue of The Journal:

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Reid—Textbook of Obstetrics: Gives you not only a clear picture of normal pregnancy and labor but sound insight as well into the medical complications that may arise.



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From the files of the
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STUDY OF MATERNAL MORTALITY



CASE #97—A 40-year-old white, married female was brought into the hospital at 7 p.m., March 17, 1960, in a state of shock. Although no history was available from the patient, her family said she had been in perfectly good health. Because she had eaten home-canned peaches, they believed she had food poisoning.

The patient had taken a half-mile walk and, upon returning, she suddenly felt weak and nauseated and then lost consciousness. She became very pale and cold.

The family stated that the patient had one child who was 14 years old. She had had a gallbladder operation several years previously but had had no particular food problem before or after the operation.

Physical examination showed her to be obese, pale, clammy and sweating. The peripheral pulse and blood pressure were unobtainable. The precordial rate was 84. The abdomen was soft with no evidence of rigidity. No bowel sounds were heard although the patient had a large copious stool after admission to the emergency room.

Because of the extremely obtuse abdomen nothing could be definitely palpated. The differential diagnosis included acute coronary occlusion with shock and possible botulism.

The patient was placed in an oxygen tent and 1/100 gram atropine was administered. A 1000 cc. infusion of 5% glucose in water was started. She was typed and crossmatched for two pints of blood.

Although she received 50 milligrams of demerol for pain at 8:20 p.m., she continued to complain of pain. At 9 p.m., terramycin (500 mg.) was added to the infusion. At 12:45 a.m. the blood pressure was 100/72 but the pulse rate could not be accurately determined.

At 5 a.m. a 600-cc. whole blood transfusion was started. At this time the patient seemed alert and responded to questioning. She still complained of abdominal pain and received 75 milligrams of demerol at 5:30 a.m. The blood pressure was now 110/64 and the pulse 104, weak and rapid.

At 8:30 a.m. March 18 the patient's hemoglobin was 9.6 grams; the red blood count, 3,300,000; the hematocrit 33% and the white blood count, 26,100. At this point the patient informed the doctor that she had missed her last menstrual period.

The apical heart rate was 84 which seemed inexplicable in the presence of shock unless it represented vagal slowing. Confined intraabdominal bleeding such as into an ovarian cyst was considered to be a possibility as was acute bowel obstruction with compressed blood supply. In either event the patient was in poor condition for operation at this time.

Plain supine and upright x-ray films of the abdomen showed a few minimally distended loops of small bowel interpreted as a low grade ileus such as is seen with pancreatitis. The shock, pain, high white blood count and excessive vomiting seemed to support the diagnosis of pancreatitis.

At 9 p.m. she became more alert. The blood pressure was 210/110 and the abdomen was less painful. Acute coronary occlusion in a hypertensive woman remained the primary diagnosis. Her condition was much improved on March 19. Vasodilator medication reduced the blood pressure to 170/80. Her color was described as good and she desired solid food.

Clinically the patient's appearance was much better on March 20 and she was taken out of the oxygen tent. She had no complaints but the pulse was still weak and irregular.

Around 4:45 p.m. she complained of numbness and began perspiring profusely. The blood pressure was 140/? and the pulse was unobtainable. At 5 p.m. she was quite pale and complained of shortness of breath. She was given 1/100 grain of atropine, Coramine and oxygen by mask.

At 5:38 p.m. she received 2 cc. of quinidine and at 5:45 p.m., one ampule of Solucortef. At 6:30 p.m. the hematocrit was 22. It was obvious that she was having intraabdominal bleeding but she was in no condition for operation. She expired at 6:55 p.m. and permission for autopsy was obtained.

The positive autopsy findings were limited to the abdominal examination. About 1000 cc. of blood with clots was found in the peritoneal cavity. A right tubal pregnancy measuring 2.5 centimeters in diameter had ruptured. There was a recent corpus luteum in the right ovary. The anatomic diagnosis was that of a ruptured ectopic pregnancy with hemorrhage.

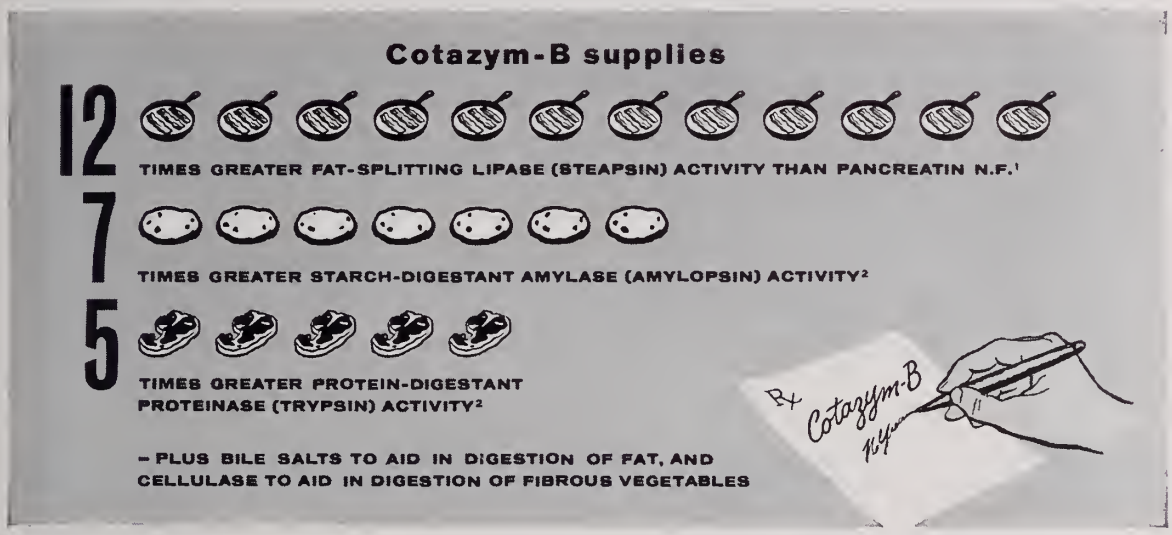
Comments

The committee classified this as a direct obstetrical death with preventable factors. They felt with the history of a missed period, a cul-de-sac aspiration should have been performed on March 18 when the findings first suggested intraabdominal bleeding. Unless the possibility of extrauterine pregnancy is considered early, the correct diagnosis is often made only at the autopsy table.

Ectopic pregnancy is estimated to be responsible for 3% of all maternal deaths. In 1960, 2 of the 23 maternal deaths (8.7%) in Kentucky were of this origin. The case reported typifies the surgical emergency with the fatal outcome usual in untreated cases.

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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PUBLIC HEALTH PAGE

The Role of the Physical Therapist in the Kentucky Chronic Disease Program

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE home care program of the Division of Chronic Disease Control of the Kentucky State Department of Health is planned to aid the referring physician by teaching the chronically ill patient or a family member techniques of home nursing care and rehabilitative physical therapy. Also included is help with nutrition needs and psychological understanding of the patient.

Currently, as the home care program has but two physical therapists for the entire State, their role is necessarily that of consultant and is not service directed.

Sends Referral Form

When the physician desires the services of a physical therapist on a case, he usually sends the county health department a referral form including the diagnosis and any contraindications. The public health nurse already on the case requests the aid of a physical therapist to establish a program of rehabilitation in conjunction with her nursing program. No individual public health discipline alone is responsible for the patient's care. Public health personnel work together as a unit for care of the whole patient rather than for care of just the affected part.

As a consultant, the physical therapist educates the nurse, patient and family member, according to the physician's objectives, in those exercises and aids most feasible for use in the particular home and for the specific diagnosis.

In determining the rehabilitation needs of the patient, the physical therapist evaluates the patient:

First, by manual muscle testing to determine the range of motion a joint may be carried by the paralyzed or weakened muscles and to determine the amount of paralysis or muscle strength remaining. The physical therapist also determines the functional ability of the patient —whether he can sit, balance, walk or use his hands and/or legs to do purposeful activities.

Second, by special sensory evaluation he determines the patient's ability to see and know where he is in the space around him, to hear, understand, talk and feel correctly. For example, if the patient has aphasia, the knowledge of whether it is expressive, receptive or global will determine the amount of retraining.

Third, the physical therapist must recognize and evaluate the psycho-sociological factors present. Consideration given to these factors early in the program will aid in avoidance of the rapid psychological and physiological deterioration often seen in chronic illness.

The physical therapist also evaluates the home environment including psycho-sociological factors as well as physical factors. When this is accomplished a realistic program can be suggested and goals established.

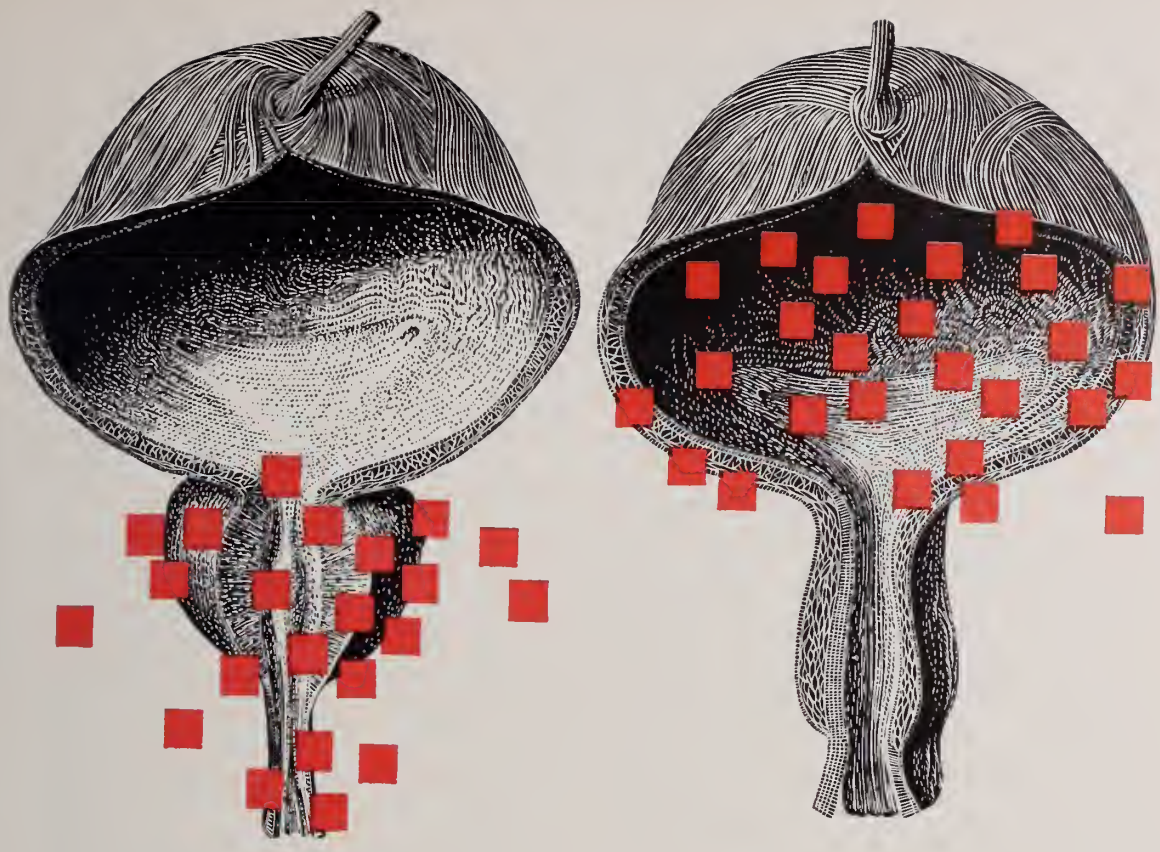
Best Exercises Chosen

When exercises are indicated, the physical therapist uses his knowledge of pathology, anatomy, physiology and kinesiology to determine those most feasible. He teaches the exercises and their importance to the patient, family member and public health nurse.

If special equipment is needed it must be

(Continued on Page 427)

This article was prepared by Paul G. O'Connor, licensed physical therapist and physical therapy consultant to the Division of Chronic Disease Control of the Kentucky State Department of Health, Frankfort, Ky.



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Q. Under what conditions does Blue Shield make an allowance for T.B. operations?

A. Doctors in private practice are paid the indemnity specified in the Blue Shield certificate of membership. No payment can be made to those doctors under contract to hospitals and paid members of hospital staffs.

Q. How many people in Kentucky are over 65 years of age?

A. Around 292,000.

Q. How many of these aged need financial assistance in meeting their medical expenses?

A. The Department of Economic Security estimates that about 175,000 are in need of help. Stated another way, this means that 117,000 can meet their responsibility.

Q. Why can't persons 65 or over apply at any time for Blue Shield?

A. A special opening period for a limited time provides some measure of "group spread" on the aged, and some persons who might delay joining are encouraged to make up their minds to take advantage of the opportunity. Too many people would delay joining until after a condition develops if the opportunity were available all the time. This would not be fair to members already enrolled. Even in payroll deduction groups for employees, those who are not members may apply only at regular reopening periods. Necessary actuarial and utilization information is obtained also by a service group setup. There have been two "open enrollment" periods in the last three years to permit any Kentuckian, age 65 or over, to apply for Blue Shield.

Q. The Standard Blue Shield subscriber's certificate states that children are not covered on the family plan until they reach 30 days of age. Are there any exceptions to this?

A. Yes. Blue Shield will make a payment for surgery during the first 30 days if the surgery is necessary to sustain the life of the child; also, both standard and preferred Blue Shield protect children from birth in many contracts. To protect children from birth increases the cost of the plans—which in turn—keeps some people from becoming members.

Q. What are the underwriting requirements for firms which desire to adopt the Major Medical Expense Program?

A. Groups of 50 or more are eligible if they have Blue Shield and the most comprehensive Blue Cross plan available. Seventy-five per cent enrollment is required, with a minimum of 50 applications. Monthly dues are computed for each group separately on a basis of ages, sex and salaries. Major medical may not be continued on a direct basis.

Q. What groups are eligible for the extended benefits program?

A. Groups of five or more, if they have Blue Shield and comprehensive Blue Cross. Percentage requirements are:

a. Groups from 5 to 15—100% of employees eligible.
b. Groups from 15 to 50—90% of those eligible must apply.
c. Groups of 50 employees or more—75% of those eligible, with a minimum of 45 applications.
d. The above percentages must be secured and maintained. There must be a contribution by the employer toward some portion of the Blue Cross-Blue Shield program.
e. Extended benefits may not be continued on a direct basis.

In Memoriam

WILLIAM JEFFERSON WALTER, M.D.
Pikeville
1867-1962

William J. Walter, 94, Pikeville, a physician there for 55 years, died at the Pikeville Methodist Hospital March 12. Doctor Walter was former Pike County health officer. The Pike County Health Center, completed in 1954, was dedicated to him because of his service.

Doctor Walter was graduated from the Lincoln Memorial University Medical Department at Knoxville, Tenn., in 1899.

STANLEY MULLINS, M.D.
Wingo
1882-1962

Stanley Mullins, M.D., who practiced medicine in the Wingo area for 57 years before retiring last year, died March 4 at the home of a daughter in Brooklyn, N. Y. He was 80 years of age.

Doctor Mullins was graduated from the University of Louisville School of Medicine in 1906. He was a native of Wingo and was honored by that community on completion of his 50th anniversary of practice there.

Doctor Mullins was also cited by the president of the Illinois Railroad in the early 1900's for administering aid to victims of a passenger train wreck at Water Valley in which several persons were killed and more injured.

PAUL WENDELL ADKINS, M.D.
Pineville
1899-1962

Paul Wendell Adkins, M.D., 62, Pineville, former president of the Bell County Medical Society, died at his home March 10. He had suffered a stroke on January 3. Doctor Adkins was a son of the late Doctor and Mrs. J. D. Adkins and was a graduate of the University of Louisville School of Medicine in 1926.

He began his practice at Insull in Bell County 28 years ago and moved to Kettle Island and then to Pineville in 1949.

JAMES H. DUNN, M.D.
Campton
1877-1962

James H. Dunn, M.D., retired Campton physician, died February 15 at the Good Samaritan Hospital, Lexington, after a long illness. He had practiced medicine for 50 years. Doctor Dunn was graduated from the Kentucky School of Medicine, Louisville, in 1907.

EDWIN LEE GOWDY, M.D.
Campbellsville
1884-1962

Edwin Lee Gowdy, M.D., 78, choked to death while eating lunch at his home at Campbellsville March 13. Doctor Gowdy was a graduate of the Hospital College of Medicine, Louisville, in 1907. He had practiced medicine at Campbellsville for 46 years until his retirement in 1953. He had been confined to bed for several years.

JOSEPHINE D. HUNT, M.D.
Lexington
1878-1962

Josephine D. Hunt, M.D., Lexington, died of a cerebral hemorrhage February 18. She had practiced medicine at Lexington for 49 years before retiring in 1956. Doctor Hunt was a 1906 graduate of John Hopkins University School of Medicine.

The Kentucky Resolution

(Continued from Page 393)

automobile front ends or used to cushion steering wheels, windshield headers or front corner posts.

The cumulative U. S. automotive death toll is now about 1,250,000 with an additional 35,000 to 40,000 coffins a year. In the ages between 8 and 24, the most common cause of death in our country is the automobile.

Physicians have taken real leadership in use of the life-saving seat belt. We must now follow the spirit of this Kentucky Resolution in the press for safety features whenever a car is purchased. Arthur Hail Keeney, M.D.

Public Health

(Continued from Page 424)

tailored to patient capability. For example, if a walkerette is indicated, its use requires the patient to have at least partial function in one arm and hand with full function on the opposite side. At times the physical therapist must design or suggest a special aid.

After seeing the patient, the physical therapist reports to the referring physician. Information included in his report often assists the physician in establishing a more complete medical history and a record of physical therapy management. The report often helps the physician in establishing a positive diagnosis on the patient.

In addition to direct home care patient consultation, the physical therapist serves as instructor in continuing educational programs of the State Department of Health. He is also available to physicians and allied disciplines for physical therapy consultation.

The 61st annual meeting of the Medical Library Association will be held June 4-8 at the Sheraton-Chicago Hotel, Chicago. Charles Hughes, Library of Medical Sciences, University of Illinois, is chairman of exhibits and Donald Washburn, D.D.S., American Dental Association, Chicago, is convention chairman.

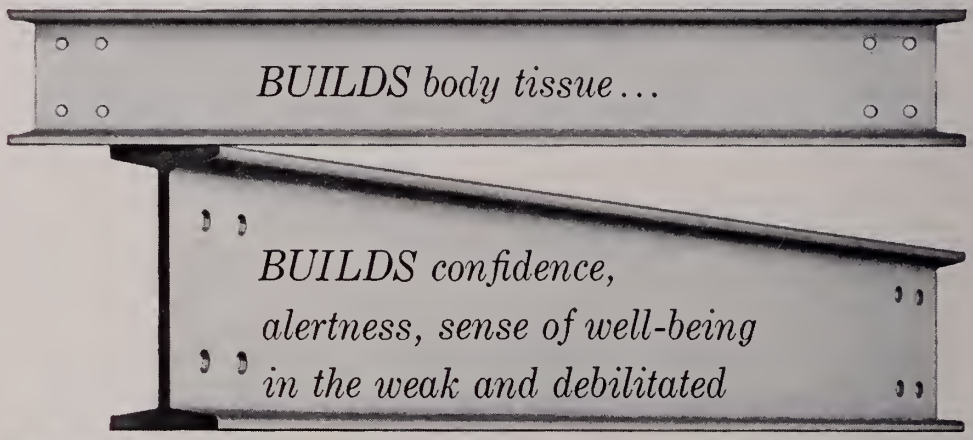
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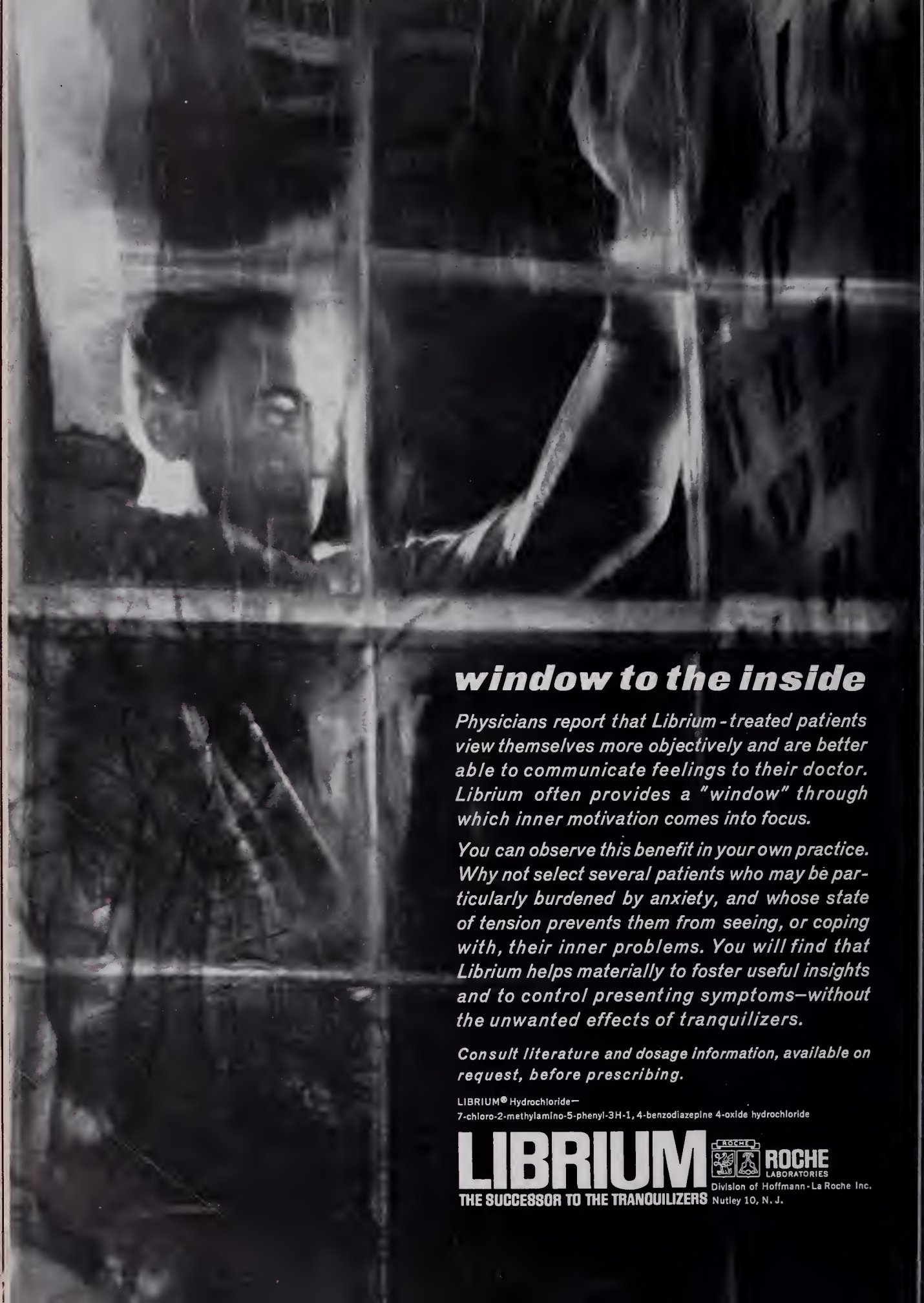
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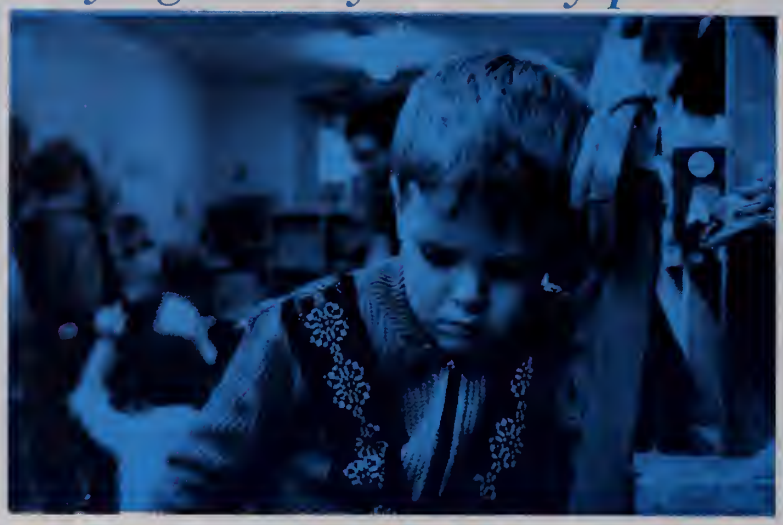
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REFERENCES: (1) Roseman, E.: Neurology **11**:912, 1961. *(2) Bray, P. F.: Pediatrics* **23**:151, 1959. *(3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: M. Clin. North America* **42**:317, 1958. *(5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.: Postgrad. Med.* **20**:584, 1956. *(7) Merritt, H. H.: Brit. M. J.* **1**:666, 1958. *(8) Carter, C. H.: Arch. Neurol. & Psychiat.* **79**:136, 1958. *(9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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*As You Like It, Act II, Sc. 7

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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See "IN BRIEF" on the next page.

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SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

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MESSAGE FROM THE PRESIDENT

We Must Tell Our Story to the Public*

FOR several years Khrushchev has been parroting the line that Communism is superior to our form of government, that the entire world will soon adopt Communism so why should the free world continue its opposition? Why not adopt Communism now so that the world can have "peace"?

The advocates of the King-Anderson measure are adopting the same kind of psychological warfare. The liberal press daily repeat their biased editorials and distorted facts favorable to their cause. They contend that government-financed and directed medicine is the only solution; that its adoption is inevitable and that the medical profession is only being obstinate and selfish "in opposing the will of the people."

Since the majority of our State is covered by a metropolitan press which is hostile to the medical profession, they have made some inroads in trying to hypnotize the public into this viewpoint. It is amazing how few laymen actually realize there is an alternative.

In talking to lay groups it is heartening and encouraging to find the opposition and indignation among the general public, many of whom have been some of the Administration's strongest supporters, when they learn the entire story of government medicine, its implications as to future cost and their care under such a system.

Within the next few weeks, it is imperative that the medical profession get its story to the public. This is not the duty solely of the Headquarters Staff, the Board of Trustees or the officials of the Kentucky State Medical Association, but of every physician. It is necessary that all of us devote our efforts to seeing that each individual citizen is informed. When the public is enlightened with all the facts, the majority will be opposed to this foot in the door approach to socialized medical care.

R. E. Pennington
Vice-President (Eastern)

**This is the second of the guest pages, written at the request of Gaithel L. Simpson, M.D., KSMA president. Henry B. Asman, M.D., vice-president (Central) wrote the page in the April issue and Walter R. Johnson, M.D., vice-president (Western) will write the page in a later issue this year.*



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THE INSURANCE PAGE



Now It Is Up To Us!

THROUGH the action of its House of Delegates at the special called session held in Louisville on April 12, 1962, the Kentucky State Medical Association became the 35th state society to endorse the new Blue Shield-American Medical Association Senior Citizens National Program. On April 19, the Board of Directors of Kentucky Physicians Mutual, Inc., likewise approved the program.

It is expected that most of the Blue Shield plans will have received the approval of their sponsoring medical societies to join in the implementation of this program within the next few weeks. The plan will then be made available on a nationwide basis for those senior citizens whose income limits permit them to qualify for it.

Recognition Needed

It must be recognized that there are certain provisions of this plan which are not entirely satisfactory to some of the physicians who will render its services. No single contract could ever be to the liking of all physicians and of all subscribers.

There is a very basic difference, however, between a voluntary plan, such as this one, and the plan which the Administration is anxious to legislate into existence. A physician-sponsored prepayment plan comes into existence only through the consent and cooperation of the medical society or societies which sponsor it and can be altered and improved at the request of these organizations if experience shows that such changes are necessary.

The important fact to remember is that we can now point out to our legislators and to the public a system of prepaid medical coverage, on a voluntary basis, which is superior to that offered through the Administration's program and which can offer *assurance of protection.*

Vote of Confidence

Through our vote of confidence in the action of the AMA Board of Trustees in its endorsement of the National Blue Shield Senior Citizens Program, we have upheld the hands of our legislative committees. Had we failed to do this, further efforts on their part to persuade our legislators to oppose the Social Security approach for providing medical care would have been increasingly futile.

It is now up to us to make the voluntary approach succeed; else, by failure to do this, we shall have defaulted to those who favor a system of compulsory medical care under government control.

W. Vinson Pierce, M.D.

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WASHINGTON NEWS DIGEST



WASHINGTON, D.C.—Supporters of the King-Anderson Bill stepped up their campaign as the House Ways and Means Committee neared a showdown vote on the legislation which would provide limited health care for the aged under Social Security.

The Kennedy Administration took over the leadership in the drive, with the President accepting an invitation to address a rally in Madison Square Garden, New York City, on May 20, sponsored by the National Council of Senior Citizens for Health Care Through Social Security.

The Administration also was organizing citizens' committees in individual states to whip up grass roots pressure for the bill. The President was asking prominent persons, such as former Democratic Governor and U. S. Senator Edwin C. Johnson in Colorado, to head such committees.

After personally pledging their support to the legislation in a White House call on the President, 27 physicians formed the Physicians Committee for Health Care for the Aged Through Social Security, headed by Caldwell B. Esselstyn, M.D., New York City, president of the Group Health Association of America. Most of the 27 are educators, hospital administrators or in other administrative posts. A majority are members of the American Medical Association.

Pointing out that the White House was able to muster only an insignificant number of doctors for the King-Anderson Bill, an AMA spokesman said at least 90% of the nation's 261,000 physicians are opposed to the legislation.

The intensified Administration drive made it imperative that physicians and other opponents of the Social Security approach go all-out at this time in their efforts against the King-Anderson Bill.

A vote was expected in the Ways and Means Committee in May or June at the latest.

Senator Robert S. Kerr (D., Okla.) reaffirmed his opposition to the King-Anderson Bill, but said he expected it would come up on the Senate floor for a vote. He said he and Representative Wilbur B. Mills (D., Ark.), chairman of the Ways and Means Committee, were conferring on legislation that would expand the Kerr-Mills program—which has the wholehearted support of the AMA—to cover more aged persons.

Under the leadership of Representative William E. Miller (R., N.Y.), who is also chairman of the Republican National Committee, some Republican Congressmen got behind the so-called Bow Bill which would permit aged persons to reduce their federal income taxes by up to $125 a year to cover health insurance premiums. The government also would issue to persons 65 years and older, who pay no income taxes or less than $125, a certificate with which to purchase health insurance.

*** ***

The Public Health Service licensed Type III oral poliomyelitis vaccine but left the decision to local health officials and physicians as to whether the oral or the Salk killed vaccine, or both, would be used this year.

Types I and II oral polio vaccine had been licensed last year and Type III was the last of the series needed for protection against all three types of polio.

Production and availability of the oral vaccine will be a major factor in the extent of its use this year.

The PHS conclusion on local immunization programs was recommended by a special advisory committee to the Surgeon General and was in line with a policy adopted by the AMA House of Delegates at Denver, Col., last November.

The PHS gave five guidelines for the local programs:

1. Organizers of community drives must be assured that adequate supplies are available before such programs are undertaken.
2. All persons in those groups selected by the community should receive vaccine regardless of past polio immunization history.
3. In general, vaccination programs using either vaccine must have careful planning and achieve a maximum of support from official and voluntary health and medical groups.
4. The plans should assure the ready availability of the vaccine in all areas of the community and for all persons within the selected target groups. Special emphasis must be directed to those areas and population groups having the lowest levels of immunization. Community-wide programs should achieve the immunization of the maximum number of persons, but no less than 80% of the pre-school children in all socio-economic groups.
5. A continuing program of immunization of infants should be incorporated as an essential feature of all organized community-wide programs.

The PHS also recommended that the three types of oral vaccines be administered sequentially, each in monovalent form at intervals of about six weeks.

"Optimally," the PHS said, "large scale immunization campaigns with oral polio virus vaccines should be conducted during the winter or spring months."

Luther L. Terry, M.D., surgeon general of the PHS, termed the licensing of the Type III oral vaccine as "another major step toward the final conquest of paralytic poliomyelitis."

"Now, two effective weapons, the formaldehyde-

(Continued on page 505)

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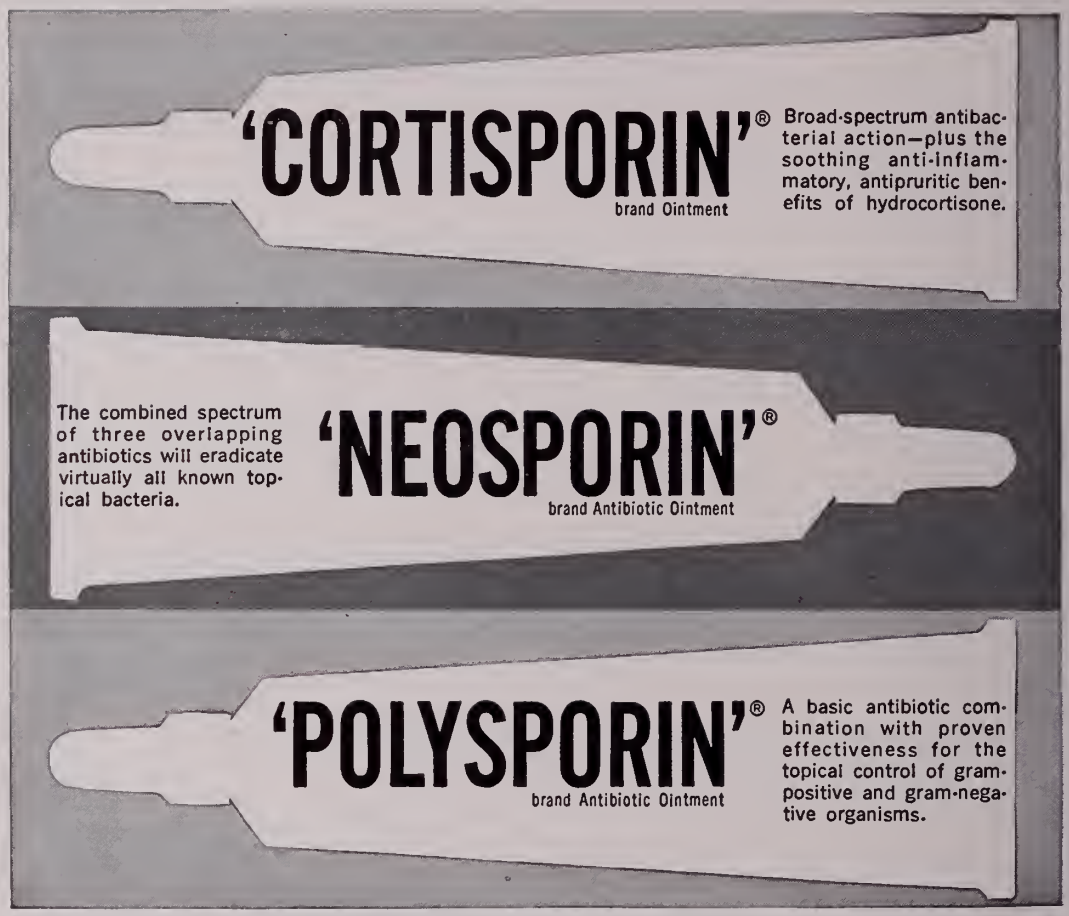
If you have been prescribing the older corticosteroids— such as prednisone, prednisolone, hydrocortisone or cortisone, and have hesitated to prescribe the newer corticosteroids because of economic consideration for your patients, you can now secure all of the clinical advantages of dexamethasone at approximately the same prescription expense. Mg. for mg., HEXADROL is approximately 6 times more potent than triamcinolone or methylprednisolone...8 times more potent than prednisone or prednisolone...28 times more potent than hydrocortisone...and 35 times more potent than cortisone.

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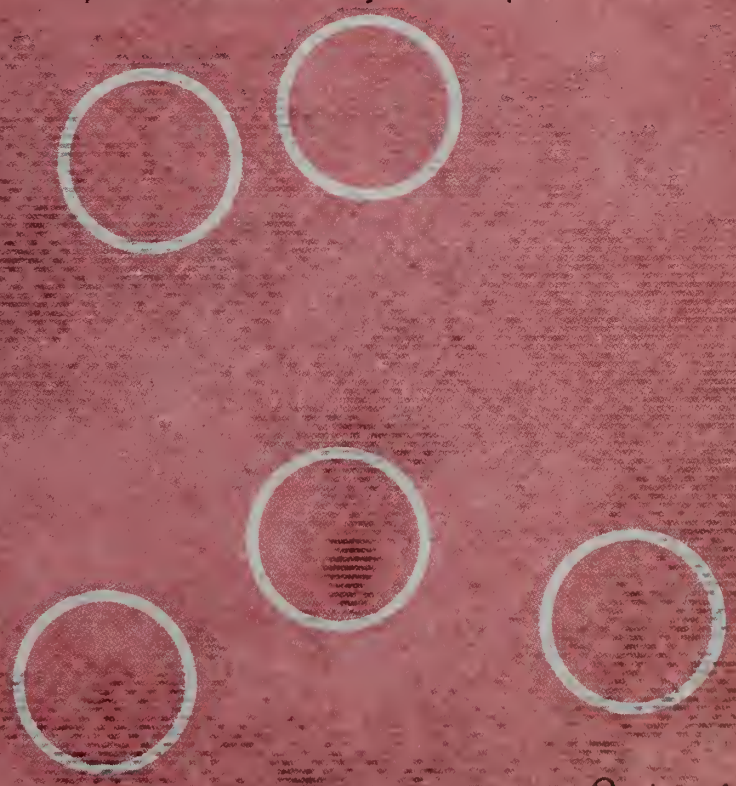
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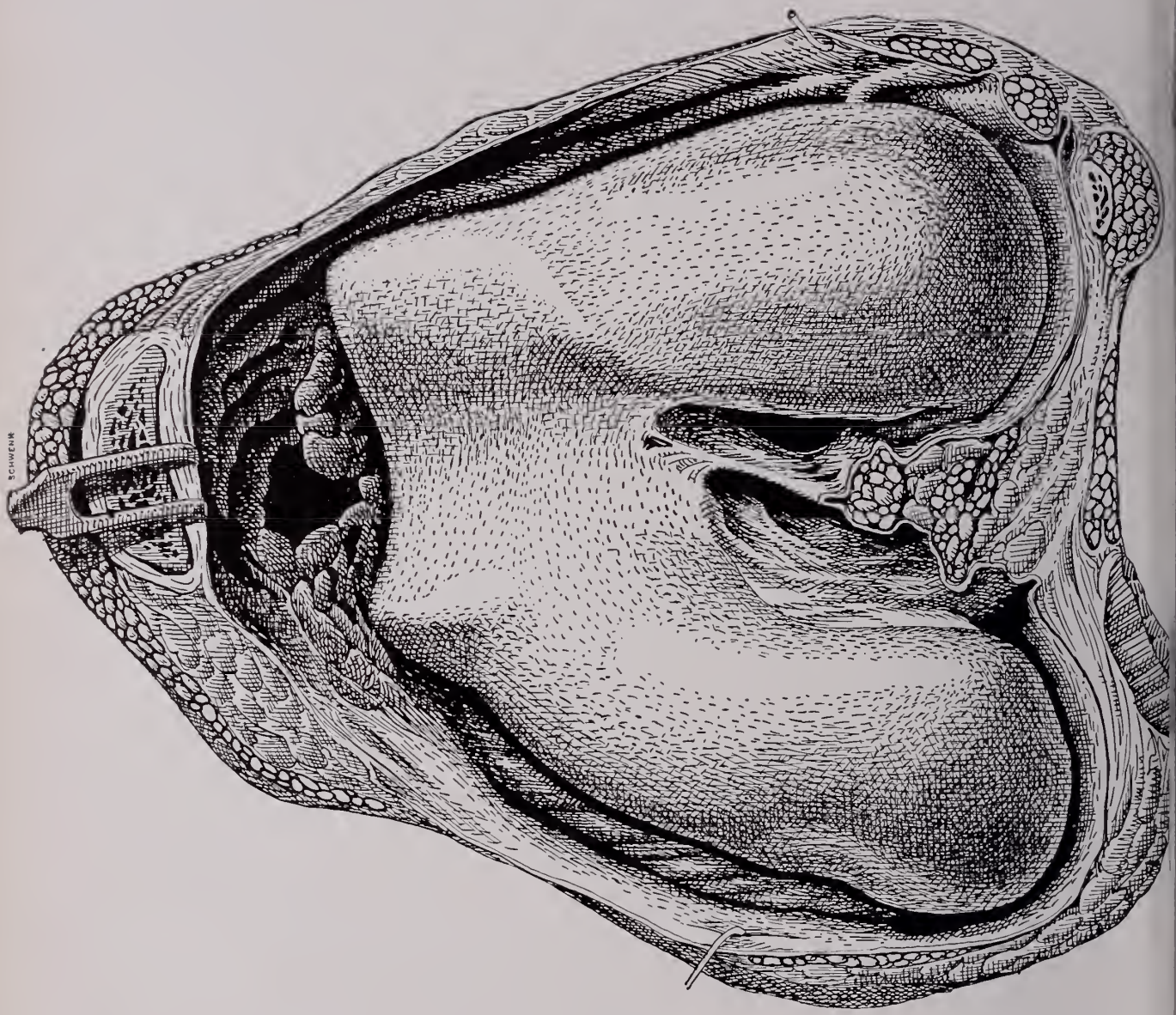


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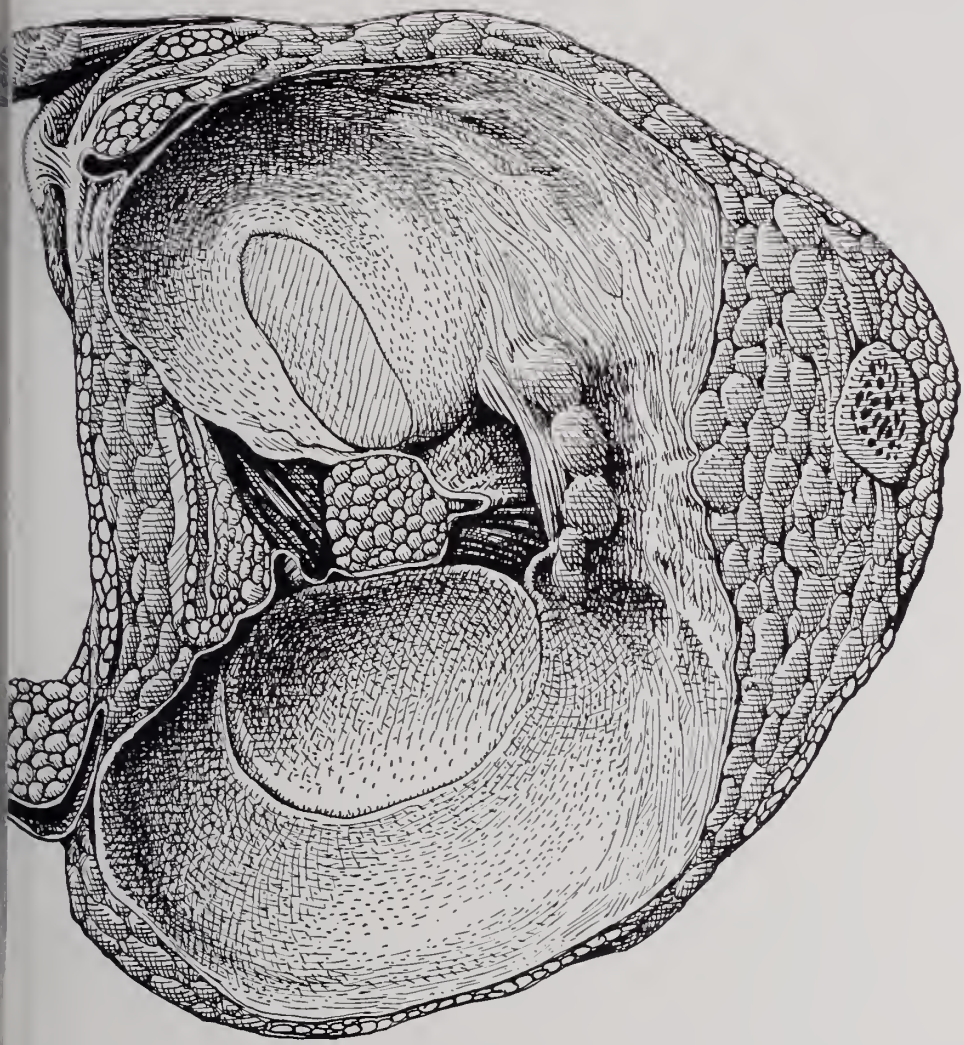
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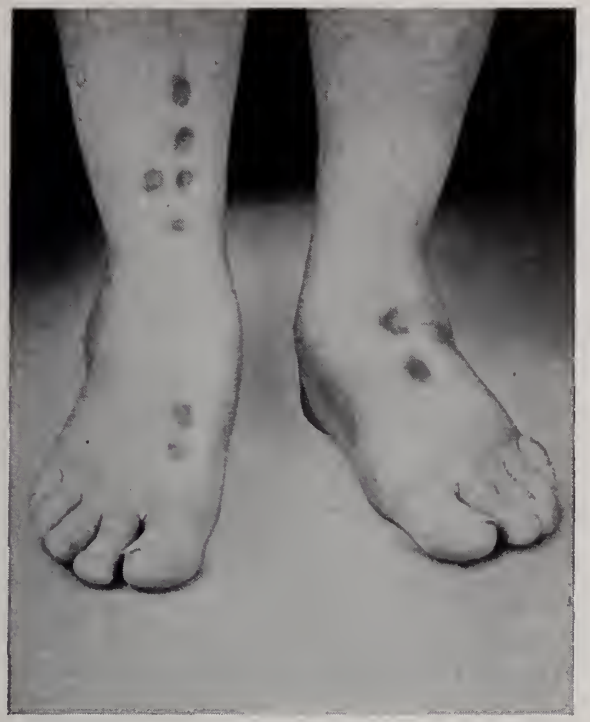
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Adult Dose: 2 tablespoons 3 or 4 times daily.

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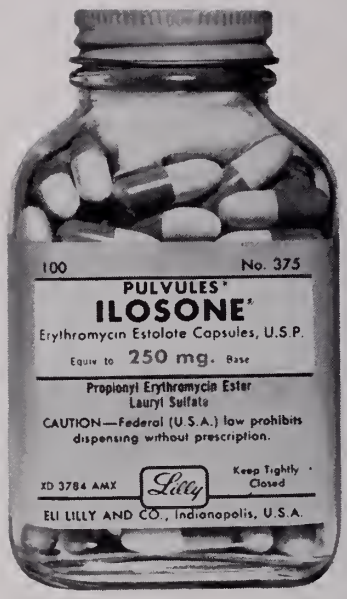


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The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Council

VOL. 60 MAY, 1962 NO. 5

Transportation and Fat Embolism*

Garrett Pipkin, M.D.
Kansas City, Mo.

Some phases of fat embolism should be assumed to be present after all injuries and bone operations. Nature usually provides a 48-hour period before critical symptoms develop. Transportation to another hospital or in the same hospital may produce a fatal result.

I WILL discuss that part of transportation which is not an accident, yet which contributes to, or becomes the final cause of the death of the patient. This is transportation after the accident, ordered and authorized by the doctor in order to obtain the best treatment available for his patient. Our pathologists call such a death caused by the physician's treatment, "iatrogenic death."

Examples of Iatrogenic Death

To point up this problem I would like to present two thumb nail sketches of iatrogenic deaths that have occurred, not in that famous hospital "elsewhere," but in my own back yard and to me in particular.

Case I. Injured at 2 p.m. in an auto collision. Brought to emergency room by private car in fair condition, but mentally confused. Taken to X-ray for skull plates. Another trip to X-ray for chest plates. Moved the third time to X-ray for flat plate of abdomen. Died at 5 p.m.

The iatrogenic cause of death at post mortem was massive fat embolism. The fracture of the pelvis was not diagnosed clinically nor by any of the x-rays.

Case II. Closed fracture of femoral shaft which was well treated in the country. The local M. D. gave the anesthetic and the local osteopath put on a double hip spica. These boys work together in rural Missouri because there isn't enough help to go around otherwise. Then they made their first big mistake. They called the city specialist and I okayed the patient for transportation. After traveling 130 miles and two trips to our X-ray department from his room, he had a sinking spell and died.

The cause of death by post mortem was fat embolism.

These two cases represent a common occurrence: i.e. a major fracture followed by transportation of the patient for some distance. or transportation several times within the hospital, is followed by an unanticipated sudden death from fat embolism. But why? My wife says that when one churns sour cream, it congeals, gets sticky and messes up the vessel. In the present state of our knowledge that is about as far as we have come with fat embolism. Yet, by dint of repetition, some means of early diagnosis, of prevention and finally hope of life saving treatment are emerging.

To understand the morbid process of fat embolism the concept of its phases are diagrammed in Figure 1. Injury gives fat access to

**From a Symposium on "Trauma and Transportation," Kentucky State Medical Association Annual Meeting, September 20, 1961.*

the circulation. An unknown factor causes it to congeal—(Transportation? Creaming? Churning?) into globules too large to pass through the capillary bed of the lungs. Given time, the globule will elongate ameboid fashion so as to pass the saddle. Circulation is slowed but not stopped. If the next globule arrives before the first one clears, mechanical obstruction results (Fig. 1-No. 2).

When acute and wide spread shock results it potentiates more emboli. Then pulmonary arterial pressure rises and right heart failure with death frequently results.

When the process is less massive the mechanical blockage deteriorates the oxygen surface tension (grease coat) of the capillary, permitting leakage.

At this point neutral fat comes into contact with tissue extracts capable of producing a lipase. Serum lipase values rise. Neutral bone marrow fat is digested into unsaturated fatty acid seven times more toxic. Fever results. Additional embolic implants called petechiae result. (Fig. 1 No. 4). Then the syndrome is cyclic until death or lipase equilibrium result.

To summarize: The phenomena of fat embolism present the following phases.

(1) Traumatic lipemia (ameboid).
(2) Shock (embolic).
(3) The illness of trauma (chemical).
(4) Death or recovery.

Diagnosis

Some clinical manifestation of fat embolism may be expected in about one-third of all patients with moderate or severe bone injury. In managing this group the major difficulty has been to differentiate between the mechanical and chemical phases and to determine whether cases are resolving spontaneously, or progressing into critical condition, and to do this promptly enough to save the life of the patient.

How Is It Done?

How can this be done? Measurement of the size of fat droplets is not practical. Salivary fat is the earliest finding but may be a false positive. No harm can be done by acting on a falsely positive test. Proper urine analysis for fat is held to be only 50% accurate and a negative test is without value. Harm may be accomplished by trusting a false negative test. Elevated serum lipase values after injury are diagnostic but unfortunately the minimum time lapse for such a determination is 24 hours. The morbid process cycles too swiftly to afford a day for diagnosis. Petechiae are apt to be antemortem; then the patient is beyond hope of treatment.

The diagnostic importance of a rapid fall in hemoglobin value, as pointed out in 1936 by Koritschorner and Sophian in the Journal of the Missouri State Medical Association, has only now reached the general literature. This fall occurs early in the syndrome, prior to or concurrent with, the initial temperature spike and 36 to 58 hours before chest plates are of value (Fig. 2). It has been called, variously, "bone shock" or "anemia of trauma." The "anemia" is lung sludge.

This fall in hemoglobin value is so much more reliable as a diagnostic measure than are tests for urinary fat that we have stopped using the latter. A hemoglobin determination has ad-



Figure 1. A concept of fat embolism. (1) Enlarged fat globules from fracture site in circulation. (2) Ameboid block. (3) Mechanical obstruction (shock). (4) Vessel permeability destroyed, capillary leakage results in petechial hemorrhage (chemical fat embolism).

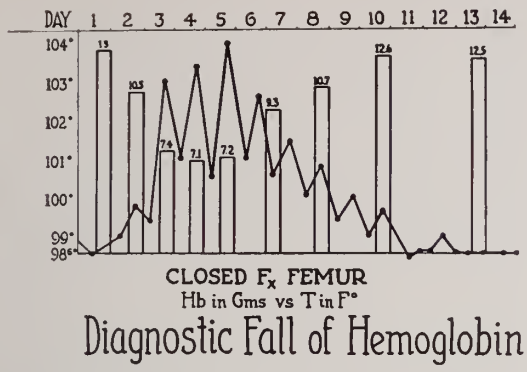


Figure 2. Diagnostic fall of hemoglobin.

vantages for no special measures are required for collection of the sample, human error is less and the time element is a matter of minutes.

Treatment

By the very nature of the morbid process there cannot be, and probably never will be, any successful treatment for the immediate overwhelming insult. But in attempting treatment several methods are now available.

The first consideration is to prevent or minimize entrance of fat into the blood stream. Careful and minimal handling of the victim at the scene of injury and a splint to support a fracture before transport to a hospital or doctor's office are indicated. For several days following trauma it is hazardous to transport the patient from one hospital to another or even from a fracture ward to the x-ray room. Tourniquets should be used during operative procedures whenever possible. Elevation of the injured limbs has practical value as fat tends to float to the top of the shaft and intravasation becomes less likely.

Oxygen therapy has a sound experimental and chemical basis in fat embolism. One school of physiology believes the endothelial lining of capillaries continues inviolate as long as it is adequately supplied by oxygen. Only when it is deprived of the protective "grease coat" of oxygen does the vessel become vulnerable and the fat globules adhere. Since fat embolism is ameboid in the earlier phases, the oxygen surface tension of the capillary bed, when it keeps the vessels slick, may determine the outcome in any given case.

Once the chemical syndrome is established the surgeon is faced with a race against time, since the condition is usually fatal or reverses itself spontaneously about the sixth day. Each petechial hemorrhage is the focal point of an anemic infarct, the extent of which may well be limited by an adequate supply of oxygen to the cross circulation. In fact, it has been reported that the neurological symptoms of injured patients could be eliminated or renewed by alternately supplying and withdrawing oxygen.

The use of blood transfusions in the stage of shock (mechanical phase) is too well established to require comment. After moderate and severe injuries, about 25% of the circulating hemoglobin sludges, mostly in the lungs. This brings up the possibility of "over transfusing"; that is, assuming that the patient's condition stabilizes, of ending up with a higher hemoglobin value than prior to injury.

Our clinical experience favors giving transfusions as the need is indicated by hemoglobin determinations.

The use of intravenous alcohol-dextrose infusions has now been established on a wide clinical basis as serving a five-fold purpose:

A Five-Fold Purpose

a. Solvent mobilizing fat for excretion.

b. With dextrose, potentiates fat for metabolism.

c. Suppresses lipase.

d. Alcohol is an excellent sedative, controlling restless patients better than narcotics, barbiturates or tranquilizers.

e. At proper rates, serves for minor analgesia for short surgical procedures.

We use 1000 cc. of 5% alcohol, 5% dextrose each 12 hours for a 200 pound man, as symptoms indicate. If he is taking fluids by mouth, a toddy of warm water, sugar, and 1 ounce of 100 proof bourbon, 3 or 4 times a day, is used.

Digitalis is an excellent tool when properly timed. The rationale of its use lies in the fact that the heart is frequently involved with petechial hemorrhages. In fact, many observers have listed the heart first in frequency among all organs to become involved. As in the brain, each petechial hemorrhage is the spearhead of a trailing anemic infarct. Electrocardiographic changes vary from simple tachycardia, to weak potential, to inversion of T waves. Our cardiologists have felt digitalis preparations were indicated on the basis of general myocardial ischemia.

As a rule of thumb, they have generally digi-

talized rapidly for pulse rates over 110 per minute and have continued maintenance doses until the pulse fell below 100. In a patient with severe fat embolism, this is usually a matter of 7 to 10 days.

Recent work with fat tagged with I-131 has again revived the "clearing factor" of heparin, not only in coronary thrombosis but also in fat embolism. Since 1940 it has been our custom to give morbid cases 50 units of Depo®-Heparin intramuscularly, twice a day, on an empirical basis. We now believe this treatment is beneficial and in this amount does not interfere with the clotting time should emergency surgery be required.

Determination Not Adequate

In selecting cases for operative procedures, it is obvious that temperature, pulse and blood pressure determinations do not adequately determine an injured patient's status. Ideally, medullary nailing should be postponed until the serum lipase value approximates normal. Where this test is not available, a practical solution is obtained by following the patient's hemoglobin values. Both Kuntscher and Boehler are emphatically against early medullary nailing procedures, which fact we have learned the hard way (Fig. 1). Boehler states: "The additional, though slight, fat embolism in the lungs and brain have caused a fatal outcome in not a few cases." He goes on to intimate that perhaps these individuals were destined to die anyway. If so, he feels that: "The peace of the dying should not be disturbed by hammer blows."

Postpone medullary nailing until the sixth or seventh day. Do not operate on a patient when the hemoglobin is falling, and the determination should be made the morning of the intended operation, not twelve hours previously.

Summary

The management of a patient through the various cycles of fat embolism has been outlined. Most surgeons are now employing a majority of the measures suggested and as a result are consciously or unconsciously preventing morbidity from fat embolism.

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Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

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Recent Developments in Kentucky's Mental Health Program*

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Kentucky's Mental Health Department now stresses rehabilitation and after care services along with increased personal responsibility for hospitalized patients. In the Community Services program, emphasis is on promotion of positive mental health, prevention of maladjustment, and agency type consultation.

IN THE Kentucky Department of Mental Health there are two major operations, the programs in the four state mental hospitals and those in the Community Services Division. I feel there have been a number of developments in both areas which should be brought to the attention of members of the Kentucky Psychiatric Association and of other practicing physicians. The developments have frequently resulted from clearer definition of our goals.

Primary Goals

We have defined our two primary goals of a state mental hospital as: (1) assisting patients by returning them to their communities at the highest level of social adjustment of which they are capable as soon as possible, and (2) assisting patients by providing the maximum total treatment and care for those not yet able to return to the community.

We believe the mental hospitals must be active treatment centers. Therefore, they cannot be warehouses for the containment of society's misfits and less adequate members. Unless a person needs mental hospital treatment, he should be placed in facilities more appropriate to his needs, and we have been trying, with some degree of success, to do this. By giving some pre-admission screening, we have been able in many cases to restrict admissions to those who might benefit from psychiatric hospitalization and we have released others who no longer need the services we offer. For those who do need hospitalization we are concerned with giving the necessary treatment and rehabilitation to allow them to return to their homes within as short a period as possible.

The objectives outlined to restore patients to their communities include the usual diagnosis and treatment, both medical and psychiatric. In addition, we offer rehabilitation and specific efforts directed toward returning patients to their communities.

Rehabilitation

In our definition, rehabilitation is the sum total of the programs designed to help patients achieve independent social living within the limits of their disabilities. (A disability may be a residual one from the illness or it may result from the treatment of the illness.) The rehabilitation services include such things as training in vocations, job adjustment, personal grooming, social and homemaking skills and fiscal responsibility.

In returning patients to their homes and to other facilities, mental hospital personnel use a variety of resources and techniques: social service work, home placements, referrals to Public Assistance, establishment of committeeships, providing and making arrangements for vocational counseling and on-the-job training, finding jobs, follow-up services and legal restoration. Mental hospital personnel work hard in this area, but so do family doctors, private psychiatrists, public health nurses, Public Assistance workers and vocational counselors from the State Bureau of Rehabilitation Services.

Essential to an effective home-going program are adequate aftercare services. Because of differences in the areas served and in medical

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†Commissioner, Kentucky Department of Mental Health.

staffing patterns, our aftercare programs have varied from hospital to hospital. Nevertheless, each hospital does have some kind of follow-up clinic and the clinics usually meet at county health departments and at mental health centers. A summary of each patient's illness with recommendations for follow-up is routinely sent to the family physician or to the referring physician upon the patient's discharge. Another copy of the summary is sent to the patient's county health department. Over the past few years over 100 public health nurses have come to our hospitals for a week of orientation to mental health and for instruction in follow-up methods. In many cases, these nurses do follow-up visits for us, especially in the areas remote to our hospitals and clinics. But even with our advances, there are still too many patients who do not receive adequate aftercare supervision.

Census Drop

Our rather dramatic drop in census (541 persons this past fiscal year) can be attributed, I am sure, to our increased emphasis on rehabilitation and return of patients to their communities. And the drop can be contrasted with the figures of a neighboring state, similar to Kentucky in economy, geography and resources. That state, which has made no definition of goals, registered a census increase of 276 last year and the overcrowding in one of its hospitals has brought about a policy of the hospital's accepting patients only on court orders. Such a step means that that state is saddled with unnecessary costs and that persons needing mental hospitalization are faced with a number of indignities, such as stays in jail. Also, there has been a considerable outcry from the state's private psychiatrists who can no longer send their patients to the state hospital on voluntary or medical certification procedures. That state is also requesting funds for buildings to house its additional patients.

In Kentucky, overcrowding in mental hospitals is gradually diminishing and patients may be admitted at any time on voluntary, medical certification and court admission procedures. We do need some new buildings but new buildings are requested merely to replace structures that are no longer adequate or safe, not for additional housing.

We realized we were inconsistent in stressing rehabilitation while our patients were unable to exercise any personal responsibility. In their locked setting, patients could not make even the simplest decision about their meals, grooming, clothes or leisure-time activities.

As a result, opening of our hospitals is now far advanced. In addition to the increased sense of responsibility in patients, we have found a number of other benefits: patients come to grips with their emotional problems sooner since they no longer argue constantly about being locked up and treated like criminals. Families feel much more secure about taking patients home on visit or release, for they know that the patient can be trusted in an open setting. (Previously, families seemed to feel that locked wards meant that even we didn't trust the patients.) With open wards, the hospital staffs seem more willing to allow a patient early home visits, for they feel confident that the patient will return since he has been able to handle the open ward situation. One benefit was expressed eloquently by a patient who said, "At last, you can get away from the people you don't give a damn about!"

Activities Programs

To further our rehabilitation efforts, we have added ward activities programs in each hospital. In this program, persons skilled in occupational and recreational techniques demonstrate and teach the techniques to the psychiatric aides so that they, in turn, may have these kinds of activities on their wards whenever possible. As a result, patients are more alert and responsive, seclusion and restraint have been drastically reduced and physical conditions that result from inactivity, such as obesity, constipation and postural deformities, are becoming less common.

For all patients, whether they can return home soon or not, we have several changes. Some, such as increased food allotments, were planned to improve patients' physical well-being. Others, such as dividing partitions between toilets, and pressing patients' outer garments, were planned to improve the patients' self-respect and dignity.

In our Community Services Division we have stressed the public health approach to mental health rather than the case service approach. The public health approach has been partly necessitated by the shortage of psychiatrists and psychologists, but we also feel that it is a more appropriate and profitable course for a state program. It is our philosophy that direct

case services should be provided by the local community if they are desired.

In the Division we emphasize the promotion of positive mental health principles and practices and we work especially with those agencies that see young people in situations of developing personalities—in schools, sunday schools and well-baby clinics.

We also stress preventive principles and practices, that is, prevention of maladjustment and unhappiness, not necessarily psychosis, and we work with personnel in welfare agencies, health departments, courts and others who see people in situations of financial, physical and social stress.

Consultation Services

Community Services personnel also give consultation in the management of emotional problems that are seen in the regular work of other agency employees. Often, the agency worker already has an effective relationship with his client that can be used to better therapeutic advantage than that achieved by sending the client to a psychiatrist in a distant clinic.

The Division's school mental health consultation program has grown to include seven persons who work exclusively with teachers, principals, guidance counselors, school nurses and other school personnel to promote positive mental health and to give consultation about problems in the classroom.

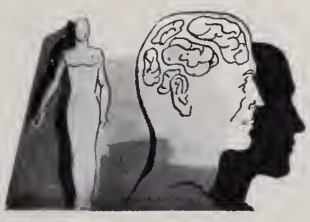
Another Division activity of interest is the program of mailing to general practitioners throughout the State the quarterly issues of *Abstracts of Psychiatry for the General Practitioner*. This pamphlet, published by the Carrier Clinic in New Jersey, has been particularly well received, and is an effort in the area of education in the fundamentals of psychiatry.

The effectiveness of the program of the Community Services Division is as difficult to assess as is a direct treatment outpatient program. We are, however, in the process of evaluating its many facets.

Research and Personnel

Throughout the Department we are devoting more and more attention to research. We have established a research committee and have recently undertaken a number of research projects, some small, some large. We are encouraging our personnel to undertake research and evaluation studies, for we feel this is a necessary ingredient in a progressive mental health program.

I am pleased to report that the quality of personnel in the Department has been steadily improving. We now have more qualified professional staff members than ever before. Governor Combs' assurance that psychiatrists in the Department will soon be paid more than the $12,000 permitted previously for state employees will undoubtedly put us in position to attract more young and dynamic psychiatrists to Kentucky. This should greatly help the programs of the Department of Mental Health.



Hypoplasia of the Lung

Porter Mayo, M.D.
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An unusual congenital lung abnormality may be suspected on routine chest x-ray and confirmed by bronchographic and angiographic studies of the small and radiolucent lung.

HYPOPLASIA of the lung is an infrequent but significant embryologic deviation. Although this fetal inconsistency may be of a varying degree, it is usually expressed in a uniform and characteristic clinical pattern. The features of the hypoplastic lung are small size by weight and volume; a marked diminution in size of the pulmonary artery; congenital bronchiectatic and bronchial cyst formation; increase in size of the bronchial vessels (systemic vessels), and emphysema of the involved lung as evidenced by a radiolucent radiograph on the side of involvement.

Diagnosis

Symptoms may or may not be present, however one usually is impressed by a history of dyspnea and recurrent infection. If suppuration in the affected lung has become significant, symptoms will be consistent with the degree of parenchymal involvement.

Clinical findings reveal:

(1) Decreased breath sounds on the involved side and increased resonance throughout (these findings may be altered by the presence of infection).

(2) Shift of the mediastinum to the affected side.

(3) Clubbing of the fingers.

(4) Limitation of motion of the involved side.

X-ray studies are of particular significance and reveal the following as related to the involved side:

(1) Radiolucency of the hypoplastic lung.

(2) Shift of the heart and mediastinal contents.

(3) Elevation of the diaphragm.

(4) Small size of the lung.

(5) A diminished to absent vascular hilar shadow and diminished to absent pulmonary arterial pulsations fluoroscopically.

(6) The exact status of the lesser circulation expressed by angiography.

(7) Herniation of the other lung.

(8) Bronchiectasis or bronchial cyst change as well as bronchial aberrations or variations as delineated by bronchography.

As previously mentioned, the degree of hypoplasia of the lung may vary. One lobe and the arterial supply to this lobe may be affected or, as in the cases to be presented, the entire lung and its pulmonary artery may be involved. Due to the structural changes the hypoplastic respiratory tissue is capable of only a minimum responsibility as related to its bodily function. This embryologic aberration is further complemented by a bronchial tree which may not only vary in size and distribution but also be plagued by multiple sacs of congenital bronchiectasis. The paradox of a small and emphysematous lung results from interalveolar breakdown.

Emphysema and Bronchiectasis

Emphysema in pulmonary tissue occupying less space than normal is also seen in cases of hypoplastic lobar arteries. Increased radiolucency in all or part of a lung is due to diminution in the size and number of vascular markings. The density of vascular markings in local emphysema may be due to a real loss of the smaller pulmonary vessels, however, in obstructive emphysema the vascular markings are simply spread out, giving the same effect. The reduction in the size of a lobe or lung has been observed in bronchiectasis with an associated

decrease in size of the pulmonary artery which supplies the affected lobe or lung. It should be emphasized that this decrease in size of vessels by an acquired chronic disease does not approach the reduction observed in the hypoplastic lobe or lung.

The right or left pulmonary artery may be congenitally absent and may occur without abnormality of the bronchial tree or lobar development. One may observe a unilobar or hypoplastic lung without cystic or bronchiectatic lesions supplied by a small pulmonary artery and anomalous systemic artery. The hemodynamics in such congenital anomalies of the pulmonary and systemic vessels to one lung may alter the flow of blood to that lung, producing symptoms. In those lung conditions of partially or completely occluded pulmonary artery flow the bronchial component must assume the sole responsibility of this dual vascular system.

In some cardiac cases this capability is more than merely beneficial; survival itself is involved. Pathologic and experimental data has proved the ability of the bronchial system to compensate by enlargement of the bronchial vasculature in those instances of diminished or absent pulmonary artery flow. The enlargement of the bronchial system is often associated with lung defects due to congenital absence or hypoplasia of the pulmonary artery. Variations of this dual system are being more frequently reported as anomalous arteries arise from the systemic circulation to supply sequestrated portions of lung.

Angiography

In those instances of hypoplasia of a lobar artery in association with interlobar sequestration angiography demonstrates a moderate decrease in size of the lobar artery and a prominent reduction in the size and number of its peripheral branches. Angiography may not be conclusive in the establishment of a diagnosis of hypoplasia because this artery even if of good caliber, may have a diminished or absent flow of blood. The combination of a small emphysematous lobe or lung in association with a pulmonary artery or lobar artery of markedly reduced caliber further complemented by bronchiectatic changes and a diminished oxygen uptake is sufficient for the confirmation of a diagnosis.

Two important mechanisms are involved in the pulmonary tissue containing bronchiectasis. The cooperative effort of both of these mechanisms divert blood into the non-diseased and functional parenchyma. Not only is the bronchiectatic disease a space occupying lesion and a functional liability but also a circulatory burden due to the collateral circulation and left to right shunt which may be imposed upon the left side of the heart. This becomes particularly important when there is a reduced competency of the cardiac muscle associated with other factors.

Reduction in the size of a lung or lobe occurs when it is bronchiectatic and is accompanied frequently by some decrease in size of the pulmonary artery supplying the affected segment.

"Liebow and others have shown that the bronchial arteries enlarge in chronic bronchiectasis. In general this enlargement is in direct proportion to the diminution in size of the pulmonary artery."

Of importance in patients so afflicted is the fact that the total pulmonary function has actually been improved after resection of the diseased parts. The clinical picture varied somewhat in the cases to be discussed due to the superimposition of infection in the second case. The gross bronchiectasis was an outstanding feature as demonstrated by x-ray. The small size and fetal like appearance of the lung by gross examination was also a striking but, perhaps, not a salient feature. Specific findings related to the vessels are included in the case presentations.

I concur with a previously expressed opinion that the pulmonary lesions were secondary to the congenital hypoplasia or absence of the left pulmonary artery.

Case Reports

Case No. 1: This 31-year-old white man was first examined on April 9, 1955. At that time the patient was employed by the Atomic Energy Commission and a notable feature of the patient's illness was complaint referable to his occupation. There were times when the patient's work required exposure to conditions of increased atmospheric pressure. A greater degree of dyspnea was experienced by the patient than by other men working under similar conditions. A review of the past history revealed one episode of pneumonia in 1947 and one episode of hemoptysis in 1952. There



Figure 1. The preoperative chest x-ray demonstrates a radiolucent left lung and shift of the mediastinum to the left. The pulmonary artery was not visualized.



Figure 2. Bronchography revealed an extensive bronchial network of normal size on the right, however, on the left bronchiectasis is evident in saccular form especially in the lower lobe.

was no recurrence. Systemic review was essentially non-contributory otherwise.

Physical examination: Height—5′7½″. Weight—144. BP—115/80. Pertinent physical findings were bilateral clubbing of the fingers, diminished breath sounds and increased resonance throughout the left lung field. The heart was shifted to the left.

Interpretation of chest x-ray studies prior to this examination had stressed the exaggerated lung markings on the right side and a clear left lung; however, the clinical findings and x-ray interpretation had not been correlated. A diagnosis of minimal inactive tuberculosis involving the upper lobe of the right lung was usually recorded. Therefore, the emphasis on disease involving the right lung was misleading and not until the physical findings and chest radiographs were assimilated was the possibility of a hypoplastic lung considered. The inability to visualize a left pulmonary artery shadow further emphasized this possibility. Bronchography and angiocardiography were performed. The studies were illustrated. (On this page. Figures 1, 2 and 3.)

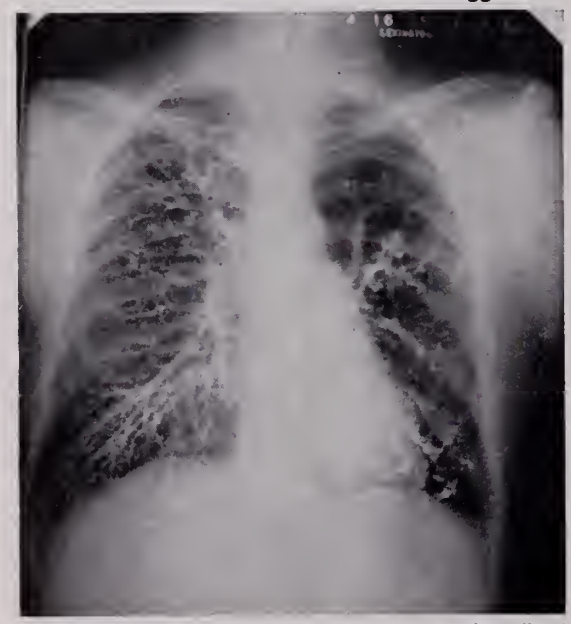


Figure 3. Angiocardiography revealed a well defined right pulmonary artery, however, this film and subsequent studies failed to outline a left pulmonary artery.

A left pneumonectomy was performed on August 16, 1955. The entire lung was extremely small and its weight was 272 grams. There was essentially no reaction around the periphery of the lung and the surface was very similar to the lung of an infant.

Bronchiectasis was manifested in both lobes by dilation of the larger bronchi and multiple, apparently blind, cystic dilation of the smaller bronchioles. Some of these cysts measured up to 2 cms. in diameter and there must have been several dozen of them.

The patient's immediate postoperative course was satisfactory; however, several months later, an infected pleural space necessitated the per-



Figure 4. The over expanded right lung is demonstrated in this preoperative chest x-ray. A diminutive left lung, mediastinal shift, elevation of the left diaphragm and scoliosis are striking features.

formance of a thoracoplasty following drainage. At the present time the patient is free of respiratory complaints and is no longer experiencing dyspnea. He is able to continue in his usual occupation without evidence of cardiorespiratory difficulty.

Case No. 2: The second case is that of a 17-year-old male who was underdeveloped physically even though he denied having to miss school or limit competition in physical activities with other children. The principal complaint was a persisting cough with expectoration of about one half to one ounce of thick yellow sputum per day. There had been no hemoptysis. Dyspnea was mild but of increasing concern. There was no history of cyanosis. He had had the usual childhood diseases. Recurring pneumonitis had been a particularly disabling factor since childhood. Physical examination revealed a youth of 17 years of age, mentally alert and cooperative, rather thin and underdeveloped. BP—110/80. Pulse—80. Respirations—16. Examination of the chest revealed a moderate flattening of the left chest wall and limitation of motion on the same side. Numerous rhonchi were audible and dullness to percussion was evident on the left side. The heart was shifted to the left; however, the rate and rhythm were normal and there were no murmurs. Clubbing of the fingers was a pronounced physical feature. A moderate scoliosis was present and the left shoulder was depressed. X-ray studies were illustrated. (On this page. Figures 4, 5 and 6.)

On June 26, 1957 a left pneumonectomy was accomplished. The lung was free of adhesions and its total weight was 250 grams. The bronchial vessels were quite enlarged and the pul-



Figure 5. Extensive saccular bronchiectasis of the left lung is evident in this oblique view.

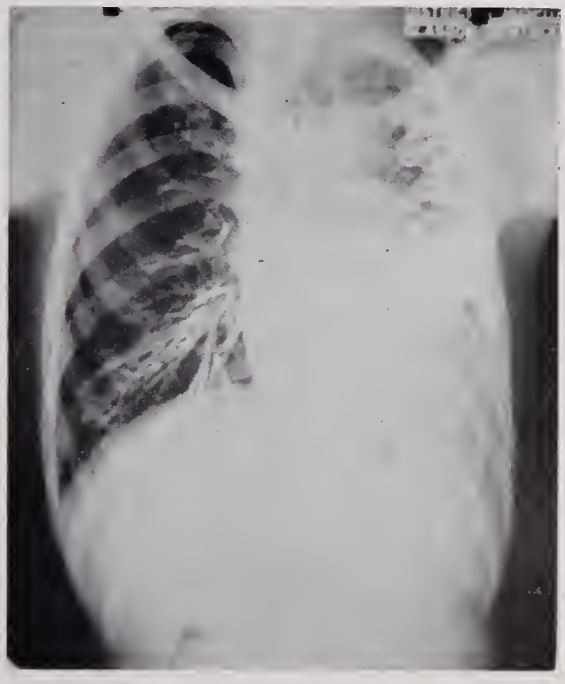


Figure 6. The PA view of the bilateral bronchogram again demonstrates the grape-like cluster of the bronchiectatic sacs on the left. The trachea can be seen to lie completely to the left side of the thoracic spine.

monary artery was markedly diminished in size. There was no evidence of an inferior pulmonary vein. The patient's immediate postoperative condition was satisfactory and his clinical condition since the operative procedure has been considerably improved. The pathology report was that of generalized bronchiectasis involving the left lung and in the apex of the upper lobe a cystic cavity measuring approximately 3 cms. in diameter. There was no evidence of pulmonary tuberculosis.

Summary

Two cases of hypoplasia of the lung have been presented. Characteristic findings were present in each case. Pneumonectomy was the surgical procedure of choice for removing the extensive saccular bronchiectasis which complicated the congentially abnormal lung.

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Small Bowel Flotation to Prevent Intestinal Obstruction

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Flotation of the small bowel by slightly distending the peritoneal cavity with normal saline solution appears to be effective in preventing obstruction.

MANY measures have been used to prevent or minimize the formation of intestinal adhesions. These measures have included the use of heparin or amniotic fluid to prevent fibrin formation, and the use of oxytocics, such as Prostigmin®, to keep the bowel in motion. Since these measures generally proved to be less than satisfactory, attention was turned toward the formation of planned adhesions to fix the bowel in an unobstructive pattern. These measures included the Noble[1] plication operation and its various modifications and the long tube complete small bowel intubation described by Satinsky and Kron.[2] Both of these methods have produced satisfactory results in our hands but have been considered by us to be too tedious to use as a routine in the type of case that needs it the most.

Method

In 1956 the thought occurred to us that the small bowel could be depended upon to arrange itself in an non-obstructive pattern if the peritoneal cavity was distended slightly with normal saline solution to permit the buoyant bowel to float upward on its mesentery in the same manner that a balloon will rise vertically from its tether. Furthermore, diluent effect of the flotation solution might delay agglutination until the apposing denudated loops of bowel had had time to seek an undulating nonobstructive pattern. Since then, we have made a practice of instilling approximately a liter of normal saline into the closed peritoneal cavity at the conclusion of any operative procedure in which there remained denudated or inflamed loops of bowel. The solution has been introduced through an ordinary straight catheter placed in the pelvis and brought out through one angle of the abdominal incision, which was then closed. After instillation the catheter was withdrawn and the abdomen gently ballotted to insure even distribution of the fluid and to assist the loops of bowel to float and seek a normal undulating pattern.

In our experience, the addition of a liter of fluid containing nine grams of sodium chloride usually has been desirable in these often greatly depleted patients. However, circumstances may be encountered when such addition of fluid and electrolyte might prove harmful. In such cases, if the method is used at all, hypotonic saline or 5% glucose in lesser amounts might be substituted.

Replacing Eviscerated Bowel

Also, we hasten to acknowledge the fact that all experienced surgeons in replacing eviscerated bowel attempt to arrange the intestines in a non-obstructive pattern below the transverse colon and carefully cover them with omentum in an effort to prevent subsequent obstruction. Our suggested method is simply an adjunct to this.

In those cases in which there has been contamination or gross soiling or diffuse peritonitis, we have, prior to closure, thoroughly lavaged the peritoneal cavity with large amounts (four to six liters) of normal saline to mechanically cleanse the area. In these cases antibiotics are added to the flotation solution. One million units of penicillin and one gram of streptomycin are the agents used and large doses of these drugs are continued parenterally as needed for several days. Continuous suction decompression and absolute interdiction of oral intake is maintained at least three days or longer until normal peristalsis has returned and flatus has been expelled.

In these contaminated cases we have made a practice of placing soft rubber tissue drains

bilaterally in the subphrenic and pelvic spaces and leading them out through postero-laterally placed flank stab incisions. These two stab incisions are temporarily sealed off with skin clips for the first twenty-four hours to prevent the "flotation" antibiotic solution from escaping prematurely. These drains are then left for at least eight to ten days before their gradual removal.

Results

At least 20 such cases have been managed in this manner since 1956 without apparent difficulty and without subsequent development of symptoms even remotely suggestive of small bowel obstruction. These cases include resection of ruptured gangrenous loops of small bowel, long delayed repair of perforation of gastric or duodenal ulcer, gunshot wounds of the abdomen involving bowel repair and resection and extensive lysis of adhesions with reduction of volvulus of segments of small bowel. We have no illusions that this procedure is the complete answer to the problem of recurrent small bowel obstruction, but we do think it may prove to be a simple and practical method of decreasing the incidence of this common and distressing problem.

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The Dedication

New KSMA Headquarters Building

3532 Janet Ave., Louisville

May 20, 1962

The Diagnosis and Treatment of Endometriosis*

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Louisville, Ky.

Endometriosis is the commonest gynecological disease of young women. Pregnancy or progestin-induced pseudopregnancy are effective methods to control the symptoms. Unless childbearing is to be preserved, castration is the recommended operative therapy.

ENDOMETRIOSIS is defined as the presence of growing, functioning endometrium outside the uterine cavity proper.[16,18] It is an invasive and metastasizing disease, and requires the stimulus of constant estrogenic and intermittent progestational hormones for growth.[10, 17, 21] The lesions are the result of periodic tissue proliferation and local invasion, followed by recurrent bleeding ("miniature menstruation") and a tendency to fibrosis and scarring.[1, 10, 11, 19, 20, 26, 27, 28] The process spreads by endometrial regurgitation through the Fallopian tubes, by direct invasion and by lymphatic and vascular extension.[8, 9, 13, 20, 24, 25, 31]

While the occurrence of aberrant endometrium in the ovary was described as early as 1899 by Russell,[20] it was not until the classic contribution of Sampson in 1921,[23] that there was any appreciation of the frequency of endometriosis or of its pathological and clinical characteristics.

The reported incidence of endometriosis varies from 5 to 28%. The incidence is highest in the fourth decade of life, the average age being 37.1 years, after 13 to 19 years of menstrual history. Endometriosis is the most common gynecological disease of women under the age of 30 years. Pregnancy and lactation exert a beneficial effect on the endometriotic process.[14, 16, 17] Consequently, the disease is most prevalent in women of high socio-economic status, who marry and reproduce late, have few children and avoid breast feeding.[16, 17, 28, 29]

Endometriosis is found chiefly in the pelvis, including the ovaries (55%), the pelvic peritoneum (14%), the Fallopian tubes (13%) and the uterosacral ligaments (4%).[1, 18, 22, 31] It is also found in extragenital and extrapelvic sites, including the umbilicus, the bladder and urinary tract, the appendix, and rarely, the lungs, pleura, diaphragm and limbs.[8, 9, 13, 18]

Undergoes Cyclic Changes

Endometriotic tissue exhibits the histologic characteristics and biologic response of uterine mucosa, but in an imperfect form. It undergoes cyclic changes in response to ovarian hormonal stimulation and develops a decidual reaction of the stromal cells during pregnancy and following the administration of progestational compounds.[4, 17, 19, 21] Growth of cystic endometriotic foci and increasing intracystic pressure resulting from hemorrhage eventually replace the endometrial tissue with granulation and scar tissue.[11, 18]

Perforation of the hemorrhagic cysts and organization of the extruded blood produce dense adhesions throughout the pelvis, together with fibrotic thickening and puckering of the serosal surfaces. This may cause adhesions of, and stricture formation in the viscera, such as the bowel and ureters. Of great clinical importance is the imperfect regression of the ectopic endometrium during pregnancy, during progestational pseudopregnancy, and during lactation; this regression follows thrombosis, necrosis and atrophy of the ectopic decidual stroma.[4, 11, 15, 18]

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The diagnosis of endometriosis is seldom easy. The symptomatology is not directly proportional to the extent of pelvic involvement, since one fourth of patients with proven advanced disease are asymptomatic. [1, 28, 29] The classic history of infertility, dyspareunia, dysmenorrhea and menorrhagia is present in only 11% of the patients.[29] The symptoms that are present most often are pain, infertility and irregular uterine bleeding.[7, 14, 21, 29]

Pain is the commonest and most constant symptom of endometriosis. It occurs as an acquired, increasing dysmenorrhea in one half of the patients, and as an acquired, increasing deep dyspareunia in one fourth. Occasionally, it may be seen as increasingly painful defecation or backache at the time of menstruation, or as the acute abdominal pain of a ruptured endometrial cyst.

Infertility is the second commonest symptom and is a presenting complaint in one third to one half of patients with proved endometriosis.[3] The Fallopian tubes are patent on X-ray examination in 85% of cases, and the cause of the infertility is unknown. It may be due to disturbed ovarian function, as one third of these women conceive following conservative operation.

Irregular Uterine Bleeding

Irregular uterine bleeding is present in some 45% of patients, although it is not a symptom of endometriosis, per se.[2, 21] It is usually due to coincident pelvic pathology, such as (a) leiomyomata of the uterus, especially pedunculated or submucous, present in one third of these women; (b) endometrial hyperplasia, present in one tenth of the patients, or (c) adenomyosis, noted in a tenth of the cases.[5] Bleeding from the bladder, umbilicus, or any other area outside the uterus, and coinciding with the patient's normal menstrual period, suggests the possibility of endometriosis; this possibility is strengthened by the coexistence of recurrently tender masses in the affected areas.

Positive findings associated with endometriosis are noted in only one third of the patients. The most suggestive finding is tender, nodular induration in the cul de sac, the uterosacral ligaments, or the rectovaginal septum. Other findings of importance are tender, fixed enlarged ovaries, and a fixed retrodisplacement of the uterus. The latter is present in 85% of cases of proved endometriosis. Other signs of endometriosis include cyclically bleeding nodules in the umbilicus, in surgical scars and in the vaginal vault and rectovaginal septum.[7]

The diagnosis of endometriosis is not reliably made on the basis of the symptoms alone.[3] Evaluation should include repeated pelvic examinations at the mid-cycle, premenstrually and during the menses. The measures that may help to make the diagnosis include hysterosalpingography, culdoscopy, sigmoidoscopy and the therapeutic administration of progestational drugs.

Hysterosalpingography is performed to determine tubal patency and possible associated uterine pathology.

Culdoscopy and colpotomy may be done to visualize the pelvic organs and their involvement by the endometriosis. However, these procedures are not without danger, due to the early involvement of the cul de sac by the disease.[15]

Sigmoidoscopy and *cystoscopy* are performed whenever involvement of the rectum or bladder by the endometriosis is suspected. The diagnosis of endometriosis is strengthened by observing a regression of the findings and symptoms of the disease following the administration of progestin for a few months. To complete the evaluation of the patient, a cytological examination of the cervix is necessary, to exclude malignancy. A dilatation and curettage is also indicated, to exclude intrauterine malignancy and other possible causes of the patient's symptoms, such as submucous myomas, endometrial polyps and adenomyosis.

Therapy

The therapy of endometriosis is influenced by the age of the patient, the severity of her symptoms and the location and extent of the disease.[3] Other factors that must be considered are the presence of associated pelvic pathology, the patient's general physical condition, and her wish to preserve the childbearing and menstrual functions.[3] The basic objectives of therapy in endometriosis are the preservation of the childbearing potential, adequate explanation of the disease to the patient and individualization of

Figure 1

THE METHODS OF TREATMENT OF ENDOMETRIOSIS

1. **SYMPTOMATIC**—analgesics, salt restriction, diuretics
2. **HORMONAL**—(a) estrogens eg. diethylstilbestrol, ethynyl estradiol
   (b) androgens eg. methyltestosterone
   (c) progestins
   eg. 17 alpha ethynyl 19 nortestosterone
   17 alpha hydroxyprogesterone caproate
   17 alpha ethyl 19 nortestosterone
   17 alpha hydroxyprogesterone acetate
   17 alpha ethynyl estraenolone
3. **SURGICAL**—(a) conservative—preservation of childbearing
   (b) radical—castration
4. **RADIOTHERAPEUTIC**

the treatment. The current treatment of endometriosis includes symptomatic therapy, hormones, operation and radiotherapy (Fig. 1).

Symptomatic Therapy

Symptomatic therapy is indicated for patients with slight or no palpable pelvic findings and mild symptoms.[17] When circumstances permit, the therapeutic advantages of pregnancy are explained to the patient. These advantages consist of marked regression of the endometriotic foci as a result of the constant maintenance of estrogen and progesterone levels and suppression of the pituitary formation of gonadotrophic hormone. Treatment with analgesics, the limitation of salt premenstrually, and the administration of a diuretic agent (such as chlorothiazide 0.5 grams daily for five days), will give the patient relief. Unless infertility is the presenting complaint, operation is not indicated in this group of women.

Hormonal Therapy

The administration of hormones will provide relief of symptoms in 85% of patients with endometriosis.[14] This therapy produces its effects by suppression of the pituitary gland, with consequent failure of ovulation, and sometimes by induction of a pseudopregnancy with decidual thrombosis and necrosis.[3, 14, 15] The latter eventuality is the therapeutically more effective of the two.

The use of hormones is generally indicated for the treatment of young, unmarried women, or of those in whom pregnancy is not feasible. Hormonal management is also valuable for patients who are poor candidates for operation, as well as for patients whose disease is too mild to warrant surgery, and for those with a postoperative recurrence of their symptomatic disease. The hormones in current use include estrogens, androgens and progestins.

Estrogens are being used less often than formerly, as the response of the endometriotic foci to their administration is too variable, and endometrial hyperplasia with breakthrough bleeding is the rule during treatment, as is profuse withdrawal bleeding when the treatment is stopped.[8, 14, 16] If estrogens are used, a reasonable regimen is the daily administration of diethylstilbestrol in five milligram doses, from the fifth to the twenty-fifth days of the menstrual cycle, or in continuously increasing doses up to 400 milligrams daily, for a period of three to nine months.

Androgens are also being used less than formerly, because when the dose is kept at a low level, ovulation continues and the endometriosis progresses unchecked.[12] At a higher level, such as with a dose of methyltestosterone greater than 200 milligrams per month, masculinization may occur. The danger of methyl hepatitis is always present as well, whenever male hormones are given. Androgens inhibit the elaboration of gonadotrophic hormone by the pituitary gland, and exert a direct antiestrogenic effect on susceptible tissues. If used, the average dose of methyltestosterone that is given is from five to ten milligrams daily for six to twelve months.[12, 14, 16]

Progestins

Progestins constitute the most effective medical treatment for endometriosis now available.[15] They inhibit the elaboration of gonadotrophic hormone by the pituitary gland and thus prevent ovulation. They also produce regressive changes in the endometrial glands and stromal decidua.[14] Progestins are best given in moderate doses for a prolonged period of time, so as to produce a pseudopregnancy. The progestational agents I favor are 17 alpha ethynyl estraenolone (Norethynodrel®) and 17 alpha hydroxyprogesterone caproate (Delalutin®), neither of which has been shown to possess the androgenic properties reported following the use of other progestational agents. Neither of these drugs has been shown to produce post-therapy ovarian suppression after 24 months of continuous therapy.

Eighty-five per cent of patients treated with progestins experience relief of their symptoms. Five to ten per cent of patients do not respond

to the therapy, possibly because of the presence of severe scar formation and extensive pelvic destruction. A complete explanation of the mechanism of success or failure of hormonal treatment is not available. The improvement of the symptoms during pregnancy and hormonal therapy is not proportional to the histologically proved endocrine response of the endometriotic areas.[4, 14] Five to ten per cent of patients fail to respond to treatment because side effects make it necessary to stop the drug. The disadvantages of progestational therapy are the development of the signs and symptoms of pregnancy, and break-through bleeding.

Symptoms of Pregnancy

The signs and symptoms of pregnancy that may develop during the administration of progestins include nausea, vomiting, fluid retention and weight gain, tenderness and enlargement of the breasts, and acne. The patient may become emotionally upset and complain of insomnia, restlessness and irritability. This emotional distress may be due to cerebral edema, or is possibly secondary to a pseudohyperthyroidism resulting from an elevated serum protein-bound iodine caused by the raised estrogen level. During progestational therapy, as in pregnancy, management of diabetes mellitus becomes more difficult. The patient may also experience rapid growth of any uterine myomas present, usually caused by a red degeneration of the myomas. Break-through bleeding that occurs during progestational therapy is usually controlled by increasing the dose of progestin for a short period.

The use of progestins must still be considered palliative rather than curative, as there is evidence that the endometriotic process resumes active growth with the re-establishment of ovulation following discontinuation of therapy.[4, 16] Castration is still the only cure of endometriosis; the induction of a progestational pseudopregnancy is the most effective method now known to control the symptoms in the majority of patients. Estrogen is as important as progesterone in maintaining the decidual reaction produced by these progestins. Most of them have an intrinsic estrogenic activity in addition to their progestational action, which enhances their effectiveness. Because of the advantage of estrogen priming, medication that is given to produce a pseudopregnancy is best begun after the proliferative phase of the menstrual cycle.[4]

The recommended dose of Norethynodrel is 10 milligrams daily, orally, for two weeks, then increasing 10 milligrams daily every two weeks, up to 40 milligrams daily; this dose is then maintained for eight months.[4, 14] No dose greater than 60 milligrams daily has been found necessary. The recommended dose of Delalutin is 250 to 500 milligrams weekly, intramuscularly, for eight months.

Surgical Therapy

Operative therapy may be conservative to preserve childbearing, or radical with castration by total hysterectomy and bilateral salpingo-oophorectomy.[6, 10, 16] Surgical management is indicated for those patients with severe, symptomatic disease who have completed their childbearing, for those in whom medical therapy is ineffective, and for patients in whom the progression of the disease suggests possible impending damage to vital structures, such as the bowel and ureters.

Surgical treatment is often indicated for the treatment of infertility to improve childbearing, and may be indicated to establish a histological diagnosis.[7] As long as functioning ovarian tissue remains, the process may persist and extend, regardless of the presence or absence of the uterus.[28] About 20% of patients with endometriosis require surgical therapy for their disease.[16]

Conservative surgery is indicated for young women under the age of 35, whose presenting complaint is infertility or pelvic pain, and in whom the Fallopian tubes are patent on X-ray examination. An initial complete investigation of the infertility is mandatory before surgical intervention is considered for this complaint.[7]

At operation, the minimal amount of tissue that must be conserved is the uterus, one tube, and part of one ovary.[17] As much of the involved tissue as possible is removed, taking care to cover the denuded areas with peritoneum, especially on the bowel wall, over the ureters and over the large vessels. However, this is often difficult because of the multiple sites of invasion, and fixation and adhesions present in the pelvic structures. Endometrial implants present on the ovary, the cervix and the uterine ligaments may be electrodesiccated

if they are small in size. Additional operative procedures that are of value are presacral neurectomy or uterosacral transection to relieve pelvic pain, and Gilliam uterine suspension to correct the uterine displacement that is present in most of the patients.[7, 16]

The results of conservative surgical therapy are only fair.[7, 17] Four per cent of the patients will require reoperation for treatment of severe exacerbation of their disease.[16] In a carefully selected group of women, fertility will be improved in one fourth to one third of those operated on for this complaint.[7, 16, 26]

Radical surgery is castration; this is curative if complete, and is indicated for those patients with extensive, symptomatic disease whose reproductive careers are ended or no longer possible due to obstruction of the Fallopian tubes, and for women of any age whose vital organs, such as bowel or ureter, are in jeopardy.[16]

A complete hysterectomy and a bilateral salpingo-oophorectomy is done. When the pelvic anatomy is extensively altered, a subtotal hysterectomy may be the safer therapy, since the total operation involves the risk of surgical injury, especially to the ureters. Bowel resection should be avoided if possible, as postcastration atrophy usually relieves the associated bowel pain and bleeding, as well as any incomplete obstruction. The administration of estrogens postoperatively will make the patient comfortable. They can be given as ethynyl estradiol 0.05 milligrams daily, or as diethylstilbestrol 2 milligrams daily.

Radiation therapy is seldom indicated for the management of endometriosis; its only use in this disease is in the treatment of patients with postoperative recurrence of endometriosis in whom complete surgical extirpation is not possible. Irradiation is contraindicated when large endometriotic masses are present, since such masses may rupture with the production of an acute abdomen syndrome. Operation is usually necessary before radiotherapy is considered, to establish the diagnosis and to exclude pelvic malignancy. Radiation therapy increases the already partial obliteration of the pelvic cavity and fails to produce castration in doses sufficiently small to spare the large bowel and bladder.

Summary

Endometriosis is a disease of civilization, most prevalent in women of high socio-economic status, who marry and reproduce late, have few children and avoid breast feeding. Pregnancy and lactation, or progestin-induced pseudocyesis are the circumstances which most effectively control the growth of the process. Surgical therapy, if indicated, should preserve the organs essential for reproduction, unless extensive tissue destruction or the age of the patient warrant a more radical extirpation.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Postabortal Tetanus

HISTORY

PATIENT Protocol #331606—L. G., a 23-year-old negro, gravida 3, para 1, was admitted on July 20, 1961, complaining of stiffness of the neck and extremities and inability to open her mouth. Her last menstrual period had begun on May 8, 1961. The present illness had its inception on July 11, 1961, when the patient experienced cramping abdominal pain and vaginal bleeding. Although the patient herself denied that any attempt at instrumentation of the uterus had been made, her sister, who accompanied her to the hospital, said that shortly before July 11 the patient had consulted an abortionist and had undergone an operation for interruption of pregnancy.

Passed Blood and Tissue

On July 17, three days before admission, the patient had passed a moderate amount of blood from the vagina, together with tissue of some type. At that time, she noted a sore throat and a stiff neck. On the following day, July 18, the stiffness of the neck had worsened, and the patient also noticed stiffness of the arms and legs. When, finally, she was unable to open her mouth wide enough to eat, the patient became alarmed, and presented herself at the Emergency Room, where the initial impression of the medical attendant was that of a peritonsillar abscess. Soon, however, the observation of trismus and incipient opisthotonos motivated prompt admission of the patient to the medical service.

On admission, the blood pressure was 120/70, the pulse 84 and regular, and the temperature 100.4° F. There was extreme nuchal rigidity. With maximum effort, the mouth could be pried open only about 5 millimeters. The tendon reflexes were hyperactive and equal bilaterally. There was moderate rigidity of the abdomen. On vaginal inspection, there was a small amount of bleeding from the external cervical os, but no other vaginal discharge.

Signs of Early Tetanus

A neurological consultant wrote that he believed the patient had signs of early tetanus, and that if the cursory available history were correct, the long incubation period and slow onset of symptoms were of relatively favorable prognostic import. A gynecological consultant described the corpus uteri as anterior, mobile, smooth and slightly enlarged. He recommended either curettage or prompt hysterectomy for debridement of the local wound in the uterus. The latter course was resolved upon, and the patient was taken to the operating room.

A midline laparotomy incision was made under general anesthesia. The abdominal and pelvic viscera appeared grossly normal. Total hysterectomy and bilateral salpingo-oophorectomy were performed without technical difficulty, following which a tracheostomy was done. During the operation, the patient was given 100,000 units of tetanus antitoxin and 2,000,000 units of aqueous penicillin. She withstood the surgical procedures well.

Plan of Management

Following operation, the patient was transferred to a quiet, darkened room and provided with constant individual nursing care. The plan of management consisted of (1) pentobarbital and phenobarbital sedation for the control of muscle spasm; (2) preparations for induction of myoneural paralysis in the event of inadequate ventilation; (3) continuous mechanical ventilation with the Mörch respirator; (4) ad-

ministration of 10,000,000 units of penicillin daily for treatment of infection, and (5) administration of hydrocortisone. Under this treatment, the patient seemed to be improving throughout the first postoperative day. She remained alert and cooperative. However, severe muscular spasms occurred following the slightest auditory stimulus. These spasms lasted for 2 or 3 seconds and were not associated with any change in respirations. Since progression of symptoms had been slow to this time, the anesthesiological consultant, who was in constant supervisory attendance, thought that the outlook was guardedly favorable.

Spasms Are Observed

On the morning of July 22, two days following admission and hysterectomy, the spasms were observed more often and seemed to start even in the absence of specific external stimuli. High fever persisted, the average temperature being 103°F. Problems were encountered in performing auscultation of the chest, as application of the stethoscope to the anterior chest wall brought about a severe spasm; from the cursory auscultation possible under these conditions, the impression was gained that there were moist rales in the right lung base.

Intravenous administration of anectine was started to relax the muscle spasms, and this measure caused prompt improvement of the symptoms. However, during the ensuing night, increasing doses of anectine were required to control what had now developed into constant spasm of the body musculature with superimposed generalized convulsions noted on two occasions during the night.

Anectine Drip Discontinued

On July 24, the fourth postoperative day, there was sufficient clinical improvement to permit a trial at discontinuation of the anectine drip. Ninety minutes after the drip had been turned off, spasms were once again observed, and the muscle relaxant had to be restarted. During the 90-minute interval without anectine, the patient was able to talk and had no specific complaints. Despite satisfactory intake and output, hyponatremia and hypokalemia developed. Respirator hyperventilation resulted in respiratory alkalosis, with consequent drop in carbon dioxide combining power. These electrolyte imbalances were corrected as they developed by appropriate intravenous infusions.

On the evening of July 24, the patient exhibited signs of severe respiratory distress and lapsed into a coma. The heart sound suddenly disappeared, and no blood pressure reading could be obtained. External cardiac massage was attempted, and mouth-to-mouth breathing was also tried, but without success. The patient was pronounced dead at 9:15 p.m. on July 24, 1961.

Permission for autopsy examination was denied. The hysterectomy specimen was reported as showing retained placental tissue and chronic cervicitis. The fallopian tubes showed acute salpingitis. The final clinical diagnosis was that of septic incomplete abortion, probably secondary to criminal intervention, with Clostridium tetani infection. The cause of death was adjudged to be respiratory obstruction complicating overwhelming tetanus infection.

Discussion

Douglas M. Haynes, M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Louisville School of Medicine.

The above case report illustrates several of the extremely serious problems which confront the physician charged with the management of a patient with tetanus following criminal abortion. The first authoritative report of postabortal tetanus was that of Chantemesse and Widal, published in 1889 some five years following the first demonstration that the disease is caused by a toxin-producing Clostridium. Since then, numerous articles have appeared in the world literature to attest to the clinical importance of this condition.

While tetanus may constitute one form of puerperal sepsis, it is more frequently seen following abortion than following full term delivery. The mode of entry of the organism into the uterus is virtually always that of direct inoculation by means of infected instruments being used to produce a criminal abortion. The symptoms usually make their appearance after an incubation period of between six and twelve days; in the case reported here, the spasms were noted at least nine days after infection, and probably somewhat longer; more accurate information was unavailable, as the patient herself denied criminal intervention.

The symptoms and signs of postabortal

tetanus are similar to those of classical tetanus of any type, but atypical variations in the clinical picture have been reported with significant frequency. For example, in some of the reported cases the only initial sign was a slight rigidity of the abdominal muscles, to be followed much later by the full-blown clinical picture of tetanus. The coexistence of postabortal septicemia of other etiologic origin may serve to mask the symptomatology in some cases. In the patient reported here, the diagnosis was not in question long, since opisthotonos was already present when she was first seen.

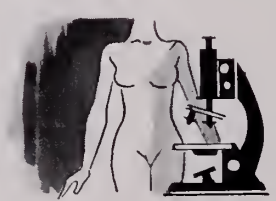
A decision to be made as soon as the diagnosis is established is whether or not to perform excision of the wound and complete debridement. In patients with superficial wounds, this treatment is clearly indicated and often, or even usually, carried out; but when the wound is in the uterus, the advisability of hysterectomy is controversial. A number of case reports have implied that hysterectomy improved the outcome, even though it is clearly unjustifiable to argue that because a patient has been subjected to hysterectomy and has survived the tetanus infection, the hysterectomy was the reason for the salvage. At any rate, experience has shown that the patient with incipient signs of tetanus tolerates immediate hysterectomy satisfactorily, as did the patient reported above; and the procedure is at least justifiable in such cases, even though it may not be strictly mandatory.

The other principles of treatment of these patients are illustrated by the case report. Of particular importance is the continuous use of sedatives in doses large enough to reduce muscle spasm partially so as to prevent the acute tetanic seizures of the disease. Muscle relaxants such as anectine are of great value, but they must be administered only when constant expert supervision is available.

Effective treatment of these very ill patients is best accomplished by close teamwork among anesthesiologist, internist and gynecologist; and in view of the constant ventilation and muscle spasm problems, the guiding intelligence should probably be that of the anesthesiologist. Of comparable importance is the contribution of the nurse, upon whose meticulous and watchful care the outcome may well depend.

Tracheostomy is important for the maintenance of adequate ventilation, and is specifically indicated in patients with spasm of the respiratory muscles, laryngeal obstruction, excessive endotracheal and pharyngeal secretions and coma. Penicillin is indicated for its specific curative effect on the tetanus infection. Despite assiduous application of all these treatment principles, the mortality rate remains high, ranging between 30 and 40%. A poor prognostic sign is the presence of an incubation period of less than seven days.

When the local lesion is not excised for any reason, tetanus antitoxin may be administered to neutralize newly produced toxin which has not yet reached nerve cells. The antitoxin is not otherwise helpful, and in a patient with postabortal tetanus who has had the uterus excised it would not be logically indicated. Some writers on the subject have expressed the opinion that a prophylactic dose of tetanus antitoxin should be administered to every woman who has submitted to a criminal abortion; but it is obvious that adherence to any such rule would presuppose a phenomenal method of case findings.



SPECIAL ARTICLES

Rumblings Along the Potomac*

WESLEY W. HALL, M.D.†

Reno, Nevada

THE immediate task—*right now* and during the weeks and months ahead—is to prevent enactment of the King-Anderson Bill in the current session of Congress. As all of us know, this would provide certain limited amounts of hospital, nursing home and home nursing care to persons eligible for Social Security retirement benefits.

We have to be on guard not only against the King-Anderson Bill itself, but also against any amendments, variations or compromises which may be introduced for purposes of political strategy. The issue of overriding importance is not the specific provisions of any one bill, but rather the *basic principle* involved in the Social Security approach to the question of health care for the aged.

As Leonard W. Larson, M.D., president of the AMA, told the House of Delegates at the recent AMA Clinical Meeting in Denver, any proposals to incorporate health care benefits into the Social Security system "would certainly represent the first major, irreversible step toward the complete socialization of medical care."

In the weeks and months immediately ahead we face our most critical legislative situation since 1949, when the Truman administration pushed for enactment of national compulsory health insurance. In fact, the situation today is far more dangerous than that of 13 years ago.

This time, our opponents are offering *just one little chunk* of national compulsory health insurance — with the benefits limited to *just one segment* of our population.

The real, ultimate objective, of course, is not simply a limited program of Social Security health care for the aged. Former Representative Aime Forand, sponsor of the original Forand Bill, let the cat out of the bag openly and publicly last year when he said:

"If we can only break through and get our foot inside the door, then we can expand the program after that."

But first things must come first. We face this immediate fact: The Administration in Washington, the leaders of organized labor and their various allies are planning — and have already launched — an all-out drive to pass the King-Anderson Bill this year.

Furthermore, they also want to capitalize on this issue in the Congressional elections next fall—regardless of whether they win or lose in the current session of Congress.

Here in Kentucky, for example, there are almost 300,000 persons age 65 or over. Statistically, they make up almost *10%* of your total population and over *15%* of your *voting* population. However, because elderly people go to the polls more faithfully than those in younger age groups, they actually account for an estimated *20 to 25%* of the voter turnout. You can see what a vital political factor they are, and why it is *essential* that we reach them with the true story about Social Security health care.

Meanwhile, along the banks of the Potomac, Secretary Abraham A. Ribicoff of the Department of Health, Education and Welfare, has set up a task force to mobilize all the Department's resources in the legislative drive. The task force is directed by Assistant Secretary Wilbur J. Cohen, perennial advocate of national compulsory health insurance for the past 20 years or more.

The AFL-CIO, through its Committee on Political Education, is gearing up its propaganda machine and can be expected to increase the intensity and venom of its efforts.

President Kennedy himself, and several of his Congressional spokesmen, have indicated clearly that top priority will be given to the issue of Social Security health care — in Congress and in the fall election campaigns.

Recent news reports from Washington indicate that Senator Anderson will attempt to get his proposal onto the floor of the Senate by tacking it on as an amendment to some other bill. In the House of Representatives there may be efforts to get the King-Anderson Bill out of the Ways and Means Committee by using the discharge petition method or other unusual parliamentary procedures. We must be alert to all possible legislative tricks and maneuvers.

Last year we presented the House Ways and Means Committee with *91* pages of testimony including over *50* reasons for our stand. Our primary objection, of

**Excerpts from the address which was to have been presented at the KSMA Interim Meeting at Owensboro, February 22. Doctor Hall was prevented from attending the session because of bad weather and flight cancellations.*

†Doctor Hall is a member of the Board of Trustees of the American Medical Association.

course, is that passage of H.R. 4222 would lead to a lower standard of medical care. But let me also try to boil down the rest of our arguments into five major points:

1. It would *not* help the 2,500,000 of the aged who are *not* receiving Social Security benefits, and it is this group which includes a high proportion of the needy and the near-needy.

2. It would provide *limited* benefits—*inadequate* to meet the medical and financial problems of the people who *really* need help — for millions of older people who neither *need* nor *want* such help.

3. By giving the federal government major responsibility for the health care of *non*-needy persons, it would alter the fundamental concept of Social Security, and it would create an *unpredictably expensive* program which would continually add to the tax burden of our working population.

4. It would be subject to continual, inevitable *political pressure* for expansion of both benefits and eligibility, leading ultimately to full-scale national compulsory health insurance for the entire population — and this would involve government control over the medical profession, our patients and our entire system of health care.

5. We *already* have existing mechanisms — voluntary, flexible and dovetailing together — which can do the job. These mechanisms are the *Kerr-Mills Law*, to aid the needy and the near-needy, and specially-tailored *voluntary health insurance plans* for the remainder of the aged who need and want them. Both mechanisms are making rapid progress, and both have great potential for constant development and improvement. We need only two or three years, without political or governmental interference, to *prove* that Kerr-Mills and voluntary health insurance make up the American-style answer.

Our job right now is to create a groundswell of public opinion in support of our position. This means that we must disperse the smog of emotion and distortion with the clear air of facts and realities.

Therefore, I urge each and every one of you to familiarize yourselves with all the basic facts on this vital issue. Campaign materials are available to you — and new information will be added steadily in the immediate future — through your county and state medical societies or directly from the AMA.

I urge you, as individual physicians and in cooperation with organized information programs by your state and county medical societies, to make the fullest possible use of these campaign materials in presenting medicine's case.

In every conceivable way, you and I and every physician interested in the freedom of medical practice must try to reach all kinds of individuals and organizations. We must persuade the individuals to write letters to their newspapers, their two U. S. Senators and their Congressmen. We must prod the organizations into adopting resolutions and *sending copies* to their Senators and Representatives in Congress. We must enlist our wives and women's auxiliaries in reaching the distaff side of the population. We must use newspapers, TV and radio in every possible way—*free* space or time, paid space or time. And, as I mentioned earlier, we must make a special effort to explain the facts on this issue to elderly people, and to golden age clubs and senior citizens organizations.

One final point: This is no time for compromise, no time for "deals."

As you may know from recent newspaper stories, Secretary Ribicoff has offered to "make a deal" with the AMA. Let Blue Shield take care of the doctor bills, he said, and let the government take care of everything else under Social Security.

Let me assure you that the AMA is not about to make any such deals. As I pointed out earlier, we are not fighting against the specific provisions of any particular bill; we are fighting *a basic principle* which we believe is wrong and dangerous.

See You

May 20

Dedication- New KSMA Building

EDITORIALS

The Time Is Now

EVERYONE is in favor of adequate medical care for the American people. At this moment the spotlight is on the provision of adequate medical care for Americans 65 years of age or above, generally referred to these days as our senior citizens. The present administration in Washington fosters legislation now knwon as the King-Anderson measure, which would provide, through the means of Social Security payment, medical care for all Social Security recipients above the age of 65 years. This would include some 17,000,000 persons and the provisions of the bill are not limited to those who particularly need financial assistance or to those who cannot afford to pay their own medical bill.

Opposing this legislation many members of Congress and the American Medical Association would endorse measures to provide medical care only for those in need of it and who cannot afford to pay for it. It is estimated that this would be applicable to perhaps 7,000,000 people over the age of 65 years. It is felt that governmental assistance from general reserves rather than through Social Security would provide a more equitable form of payment.

The AMA and the National Blue Shield have collaborated in offering to the group of persons over 65 years with an income up to $2,500 for a single person and up to $4,000 for a couple a Blue Shield Program specifically tailored to their needs. The various Blue Shield plans, the country over, have been asked to consider, and if possible endorse, this plan in order to make it effective nationwide.

The Board of Trustees of the Kentucky State Medical Association on Thursday, March 29, considered this proposal and approved it. A special meeting of the House of Delegates was called for Thursday, April 12, to act upon the motion of the Board of Trustees. Most county societies met during the two weeks interim to consider the matter in detail and inform their delegates regarding the proposal.

The meeting of the House of Delegates on April 12 was attended by more than 100 elected county society delegates. The proposal was presented by Vinson Pierce, M.D., and a free discussion open to every delegate followed —about four hours were consumed in discussion. Vigorous difference of opinion was quite honestly and well expressed by many of those in attendance. In the final voting the action of the Board of Trustees was approved by a very substantial majority, and Kentucky became the 55th Blue Shield organization to endorse the plan proposed by the AMA and the National Association of Blue Shield.

Opposition to adoption of this measure was based upon certain inequities and many imperfections in the plan as proposed. It is certain that the measure is far from ideal and it does contain many imperfections and some very patent inequities so far as a fee schedule is concerned. It is to be hoped that with continuous revision and improvement these may be adjusted more nearly to the satisfaction of all concerned.

The proposal by the AMA and National Blue Shield is not a hurriedly put together measure. It has been in process of formation for the past two years, and imperfect as it may seem, it appears to be the most adaptable plan that can be offered at the present time. Its nationwide adoption has been a matter of considerable urgency during the past month. This is occasioned by the avowed intention of the Administration to step up its time schedule and quicken the impetus for adoption of the King-Anderson Bill during this Congress. It is generally believed that an all-out effort to push this legislation to passage will begin with the President's address in Madison Square Garden on May 20.

The AMA has long opposed the King-Anderson type of legislation and has very strong support among many members of Congress. Those legislators favoring our position have urgently

requested that an acceptable counter-measure to the King-Anderson Bill be offered as a basis for effective opposition; hence, the urgency for nationwide adoption of the AMA and Blue Shield Plan as offered.

On April 13 Edward R. Annis, M.D., spoke before the Fayette County Medical Society and its guests. Doctor Annis in his very comprehensive and vigorous manner supported the AMA's position in opposition to the King-Anderson Bill and most heartily endorsed the AMA and Blue Shield Plan as projected. He thinks that if this bill can be defeated or postponed during the present Congress its possibility of enactment will be greatly lessened for the future. He senses a substantial shift of sentiment away from the Administration's proposal for medical care of 17,000,000 older people under the Social Security program. He feels that the proponents of this legislation are losing ground as rapidly as the American people become more informed as to its true nature. He pointed out that a Gallup Poll reported on April 1, 1962, showed 55% of the American people answering the question specifically in favor of the Social Security approach; 10 months ago response to a similar question in the Gallup Poll reported 67% in favor of the proposal. He believes that concerted, intelligent and unremitting action on the part of physicians and their friends to keep their legislators informed will be the most effective means of defeating this bill. Doctor Annis is a lifelong Democrat.

On April 16 Durward G. Hall, M.D., a practicing general surgeon and Republican Congressman from Springfield, Mo., addressed the Jefferson County Medical Society. He brought a message of encouragement to the profession in our present legislative conflict. He heartily endorsed the adoption by our State of the AMA-Blue Shield program and feels that with the national approval of such a plan, the strongest possible instrument will be placed in the hands of those legislators favorable to our position. He urged upon us the most earnest and widespread effort to inform our friends, our patients and all with whom we may have the opportunity to speak, the position of American medicine in this controversy.

We have been through critical periods of legislation before and by concerted effort have at least stayed the march toward socialization of our profession. We are again in the midst of a crisis. The Administration in Washington at this time enjoys unusually wide popular support. It is reported to be determined, for political advantage, to push through this law this year. We oppose it for very sound reasons concerned more with the welfare of the American people than with our own personal interests. The time to work is now.

Sam A. Overstreet, M.D.

Kentucky Medical Care Program

IN August of 1960 shortly after the passage of the Kerr-Mills Bill concerned with medical care of the indigent aged a special session of the Kentucky Legislature was called. The Kerr-Mills program was endorsed and machinery was set in motion for its implementation in our State. We as physicians regarded it as an appropriate measure of legislation, and while there was considerable difference of opinion among physicians the general thought prevailed that we as the medical association and as individual physicians should facilitate the operation of this law to the very best of our ability.

We were fortunate in two respects; in the first place, it was not difficult for us to implement the Kerr-Mills provision because there were no programs already in operation that would be in serious conflict. Also our physicians generally accepted this as a forward looking plan for indigent medical care and offered it their active support. Not very many took a negative attitude nor tried to sabotage the program by either active opposition or passive neglect. Furthermore, the Kentucky State Medical Association officially adopted this spirit of cooperation.

There was a high percentage of participation by practicing physicians. The Commissioner of Health and his Department also made every effort to integrate their plans with this new program of indigent medical care. It is certain that in some other states the Kerr-Mills program has been opposed by the medical profession collectively and individually and has been passed over by some state departments of health.

At the interim meeting of the Kentucky State Medical Association in Owensboro on February 22, 1962, William H. McBeath, M.D., acting director of the Division of Medical Care with the State Department of Health, reviewed the accomplishments of our medical care program from its inception to that date and presented data which was fairly accurate up to January 1, 1962, representing the first full year of operation. His report was encouraging with regard to the accomplishments of this program. Those of us who heard him had the feeling that he himself, representing the Department of Health, Education and Welfare, and at the present assigned to Kentucky State Department of Health, was doing everything that he in his position could in order to assure the greatest return in improved health care to those eligible for benefits.

He reported that there are approximately 292,000 citizens in the state of Kentucky over the age of 65, and of these about 60% are potentially eligible for the benefits of the Kentucky medical care program, in one category or another. Something like 175,000 elder Kentucky citizens are therefore concerned. During the year of 1961 an estimated 15 to 20% of this number, or 36,500, actually received medical care. Professional service was rendered by 1600 private practicing physicians on a voluntary participating basis. These were general practitioners and specialists in almost every category. They were reimbursed in the amount of $540,000.

Dr. McBeath in his comments took account of criticisms that have been made concerning the program. It has been thought that the range of benefits provided is too narrow. He did not think this criticism entirely justified. The program pays for essentially all of the drugs that would be required for elder citizens. There are very few private insurance policies and certainly no other government programs in effect at the present time so liberal in this particular. The dental services provided appear to be quite ample and flexible. He pointed out that the Kentucky medical care program has, from the first, been sponsored, encouraged, and guided by every professional group in the State represented in Allied Medical Council and concerned with good health. He felt that the scope and quality of work provided in this program is highly commendable.

The program to date has succeeded because of the good will and cooperation of so diversified a group of individuals and organizations concerned with health. Operation of the plan in 1962 is increasingly effective and continues to have the support of the providers of private medical care and the Public Health Organization.

There has been a demand for widening the scope of coverage and adjusting to a more practical level the number of calls for which a physician may be paid during one year. More effective use of accredited nursing homes is sought. Extension of the hospital care has already been accomplished and will probably be further improved.

Finally, if this program is to provide adequate relief for the group for which it was designed, care must be taken by all concerned that it is limited to those individuals who are in fact eligible. Abuses of the privileges and provisions of the plan must be studiously avoided. The continued good will and cooperation of physicians and other providers of health items must be maintained. Our record to date has apparently been better than most of the states who have implemented the provisions of the Kerr-Mills plan. We, as private practicing physicians, must continue to do our part in attaining these objectives.

Sam A. Overstreet, M.D.

They serve God well, who serve His creatures.
—Caroline Norton

ORGANIZATION SECTION

Outstanding Scientific Program Slated For KSMA Session

An outstanding scientific program is being shaped for the coming Annual Meeting of the Kentucky State Medical Association September 18-20 at the Columbia Auditorium, Louisville, according to President Gaithel L. Simpson, M.D., Greenville. Chairman of the Program Committee is Edmund D. Pellegrino, M.D., Lexington.

The Lyman Beecher Todd, M.D., Memorial Annual Meeting should be of top flight interest to all in the profession in Kentucky. Doctor Todd, for whom the meeting is a memorial, practiced in Lexington and was president of KSMA in 1881.

The Tuesday morning session September 18 will have as its theme, "Management of Heart Disease in Pregnancy." Walter S. Coe, M.D., Louisville, will be moderator for this session.

Wednesday morning the theme will be "Management of Thoracic Emergencies." Jerome C. Cohn, M.D., Lexington, will moderate this September 19 discussion.

"The General Aspects of Emotional Problems" will be considered at the Wednesday afternoon session, September 19 and this meeting will be moderated by Spafford Ackerly, M.D., Louisville.

On Thursday morning, September 20, there will be a symposium on athletic injuries with O. B. Murphy, Jr., Lexington, presiding.

There will be a number of class reunions of alumni from the University of Louisville School of Medicine during the 1962 Annual Meeting. Classes from the following years will hold reunion get-togethers: 1912, 1917, 1922, 1927, 1932, 1937, 1942, 1947, 1952 and 1957. A large attendance is expected at most, although classes were small in 1917 because of World War I and in 1922 directly after the conflict.

Doctor Simpson Is Honored by Ky. Public Health Assn.

Gaithel L. Simpson, M.D., Greenville, president of the Kentucky State Medical Association, received the annual award of the Kentucky Public Health Association at its meeting April 11 at Louisville, for outstanding individual contribution to public health in "his diligent efforts over many years to meet the problems of indigent medical care in Kentucky."

Russell E. Teague, M.D., Frankfort, commissioner of health, made the presentation.

Governor Bert T. Combs of Kentucky addressed the 14th annual session of the group which was attended by some 700 doctors, nurses and health workers of the State.

Miss Sarah Stice, Frankfort, is the new president of the Association. Nick Johnson, Frankfort, was named president-elect. Other new officers are: Charles Acuff, Frankfort, vice-president; Mrs. Almeda Weaver, Shelbyville, secretary, and R. L. Cooper, Murray, and Miss Martha Logan, Louisville, directors.

Dedication Set For May 20; Ceremony at 2 P.M.

All members of the Kentucky State Medical Association and the public are urged to attend the dedication program for the new Headquarters Office of the KSMA and are assured of a warm welcome, according to Gaithel L. Simpson, M.D., Greenville, KSMA president. The dedication ceremony will take place at 2 p.m. May 20 when President Simpson will officially accept the keys to the new structure from General Contractor Stanley Lichtefeld.

Distinguished guests will include Governor Bert T. Combs of Kentucky and Mayor William O. Cowger of Louisville and the principal address will be made by American Medical Association President Leonard W. Larson, M.D., Bismarck, N. D. George F. Brockman, M.D., Greenville, chairman of the KSMA Building Committee will open the ceremonies and the invocation will be made by the Rev. Paul Stauffer, pastor of the First Christian Church of Louisville. A prayer of dedication will be delivered by Wyatt Norvell, M.D., New Castle, chairman of the KSMA Board of Trustees.

For the complete Dedication program and a full story about the new Headquarters Building see the April issue of The Journal.

Doctor Rusk Speaks in Louisville

Howard A. Rusk, M.D., New York City, chairman of New York University's Medical Center's Institute of Physical Medicine and Rehabilitation, spoke at a dinner meeting in Louisville April 11, launching the public phase of a drive to raise $650,000 by May 31 to build a new Rehabilitation Center at Louisville.

If raised, the money will match funds provided by the Hill-Burton Act to build the $1,300,000 center. More than $200,000 has already been raised in advance gifts. The 100 doctors participating in the drive are headed by W. McDaniel Ewing, M.D., chairman and Everett H. Baker, M.D., and Louis M. Foltz, M.D., vice-chairmen.

Special Meeting—KSMA House of Delegates

Thursday, April 12, 1962



Pictured at the Kentucky State Medical Association House of Delegates session April 12 at Louisville: Left to right, Sam A. Overstreet, M.D., Louisville, speaker of the House, and Wyatt Norvell, M.D., New Castle, who served as chairman of the Committee of the Whole and presided while the Committee was in executive session.

The meeting was called to order by Sam Overstreet, M.D., Louisville, speaker of the House. When a quorum was reported present, Doctor Overstreet stated that the House had been called into special session to consider a recommendation of the Board of Trustees on the joint proposal of the American Medical Association and the Blue Shield to provide medical care for our senior citizens.

Following the passage of a motion to limit debate to five minutes per discussant, the House resolved itself into a Committee of the Whole and then went into executive session. (It was reported that while the House was in executive session, which was approximately three hours, 30 physicians spoke.)

When the Committee of the Whole reported back to the House of Delegates in regular session, it recommended the passage of the following resolution, as amended:

RESOLUTION

Kentucky State Medical Association
House of Delegates

SUBJECT: NATIONAL BLUE SHIELD SENIOR CITIZENS PLAN

Whereas, the American Medical Association and the National Blue Shield have jointly recommended a health insurance plan called the National Blue Shield Senior Citizens Plan, covering single persons over 65 years of age with income not exceeding $2,500 per year, and married persons over 65 years old with a total income not exceeding $4,000 per year, and

Whereas, the National Blue Shield, through its affiliate plan in Kentucky, the Kentucky Physicians Mutual, has presented to the KSMA the plan and fee schedule for senior citizens in Kentucky and is requesting that the Kentucky State Medical Association approve the plan, since it is a uniform national plan being offered throughout the United States, and

Whereas, the Kentucky State Medical Association finds there are some undesirable inequities in the proposed plan, (1) especially in in-hospital medical care, and (2) in not providing adequate non-surgical home care, and

Whereas, the Kentucky State Medical Association has carefully studied the proposal and although there are facets of the plan which are not desirable, the KSMA believes that it is the best proposal thus far submitted, and,

Whereas, the Kentucky State Medical Association recognizes an existing need for satisfactory medical and surgical insurance coverage for its senior citizens, and

Whereas, it feels that in a free economy competition is essential to achieve the best results, now therefore be it

Resolved, that the KSMA House of Delegates accept the National Blue Shield Senior Citizens Plan, with the provision that the experience of this plan be presented to the KSMA by April 1, 1963, for further study and consideration, and be it further

Resolved, that the program in Kentucky shall be known as the Kentucky Senior Citizens Plan, and that doctors of medicine in Kentucky be asked to become participating physicians in the plan, and be it further

Resolved, that the House of Delegates of the Kentucky State Medical Association strongly encourage other insurance carriers to develop and offer appropriate plans for the care of elderly Kentuckians of low economic status, and be it further

Resolved, that any such plan proposed by any insurance carrier will have provisions that are the same as or better than the National Blue Shield Senior Citizens Plan. Any carrier selling such a plan shall be expected to report on experience with the plan in Kentucky by April 1, 1963.

AMENDMENT

It is recommended that further study of the senior citizens program be instigated toward the early inclusion of all desirable medical services as well as by the development of adequate and satisfactory controls.

* * *

Both the resolution and the amendment passed by better than a two-to-one majority.

The Speaker of the House expressed appreciation to the members for the kind spirit in which it had considered this important question and to Wyatt Norvell, M.D., New Castle, who served as chairman of the Committee of the Whole and who presided while the Committee was in executive session. The meeting was adjourned at 4 p.m.

Nuclear Medicine To Be Main Topic At 111th AMA Annual Meeting

"Medicine in the Atomic Age" is the theme of the American Medical Association's 111th annual convention to be held at McCormick Place in Chicago, June 24-28. Many Kentucky physicians are expected to attend all or part of the sessions since the convention city is within easy reach of the Bluegrass State.

There will be a special half-day session entitled "Nuclear Medicine—Present Achievements and Future Promise" on Tuesday morning June 26 sponsored by the AMA Council on Scientific Assembly. The program chairman is Lee E. Farr, M.D., Brookhaven National Laboratories, Upton, N. Y., a member of the Council, and Stuart W. Lippincott, also of Brookhaven, will be the moderator.

Subjects and speakers are: "The Place of Cobalt 60 in the Management of Human Cancers," Gilbert H. Fletcher, M.D., University of Texas, M.D., Anderson Hospital and Tumor Institute; "The Present Place of Radioactive Iodine in Management of Thyroid Disease," Brown M. Dobyns, M.D., Cleveland Metropolitan General Hospital; "Why Radioactive Isotopes in Diagnosing Liver and Kidney Disorders,?" George V. Taplin, M.D., University of California Medical Center at Los Angeles; "Has the Nuclear Reactor a Future Plan in Cancer Therapy?," Doctor Farr; Alpha Particle Radiation in the Pituitary in Various Chemical States," John H. Lawrence, M.D., University of California at Berkeley; "Radioactive Fallout—Its Significance for the Practitioner," Charles L. Dunham, M.D., Washington, D. C.

New Research Forum

A new Research Forum, sponsored by the Council on Scientific Assembly, will be offered June 26, 27 and 28 with new and original papers being presented at 12 different sessions. Subjects to be covered Tuesday will be cancerous growths and peptic ulcer and other problems related to the stomach; the second day, Wednesday, heart disease and transplantation of tissue and organs as well as rheumatic and muscle diseases; Thursday, liver diseases and anesthesia and diseases causing low body temperatures.

Edwin H. Ellison, M.D., Marquette University School of Medicine, Milwaukee, is chairman of the committee which selected participants for the forum.

A one-half day scientific session June 25 at 9 a.m. will be devoted to mental health. Samuel P. Newman, M.D., Denver, chairman of the AMA Council on Scientific Assembly, will preside.

There will be a full-day scientific session June 28 devoted to the problems of teenagers. In the morning the physical aspects of puberty and adolescence, teenage problems in boys and girls and the social influences on adolescent behavior will be discussed; in the afternoon, the teenager and physical fitness, teenage skin problems, teenager orthopedic problems, gynecologic problems in teenagers and the psychiatric implication of the teenagers' problems.



Pictured at the meeting April 13 at Lexington sponsored by the Fayette County Medical Society: Left to right, Harvey Chenault, M.D., Lexington, president of the Society; Guest Speaker Edward R. Annis, M.D., Miami, Fla., and M. Randolph Gilliam, M.D., Lexington, president-elect.

Fayette County Guests Hear Annis Explain King Bill

Two former governors of Kentucky, high officials in the State Administration, members of the Legislature and many officials of county and city governments were guests of physicians at a meeting Friday, April 13, at Lexington, sponsored by the Fayette County Medical Society and addressed by Edward R. Annis, M.D., Miami, Fla.

Carl Norfleet, M.D., Somerset, former KSMA vice president and distinguished service medal winner, was recognized by the society on his 81st birthday.

Doctor Annis told the crowd, estimated at more than 400, that the Kennedy Administration realizes that if it cannot pass the King-Anderson legislation during this session of Congress, it may not be possible to pass it. He pointed out that a recent Gallup poll showed that 55% of the people want the King-Anderson legislation, whereas only 10 months ago, 65% of the people said they wanted it.

Doctor Annis explained that government pressures were making it increasingly difficult for him to get television and radio time. In three cities he was recently denied the right to purchase time on TV. One newspaper refused to send a reporter to cover a meeting.

He questioned whether or not the Administration really wants to give the people all the facts. He asked his audience why President Kennedy has refused, from the very first day he was in office, to see a representative from the American Medical Association to discuss the medical care for the aged problem. Doctor Annis asked why Abraham Ribicoff, Secretary of Health, Education and Welfare, refuses to debate with him in public, and he said that Dr. Gallup refused to do a poll for the AMA.



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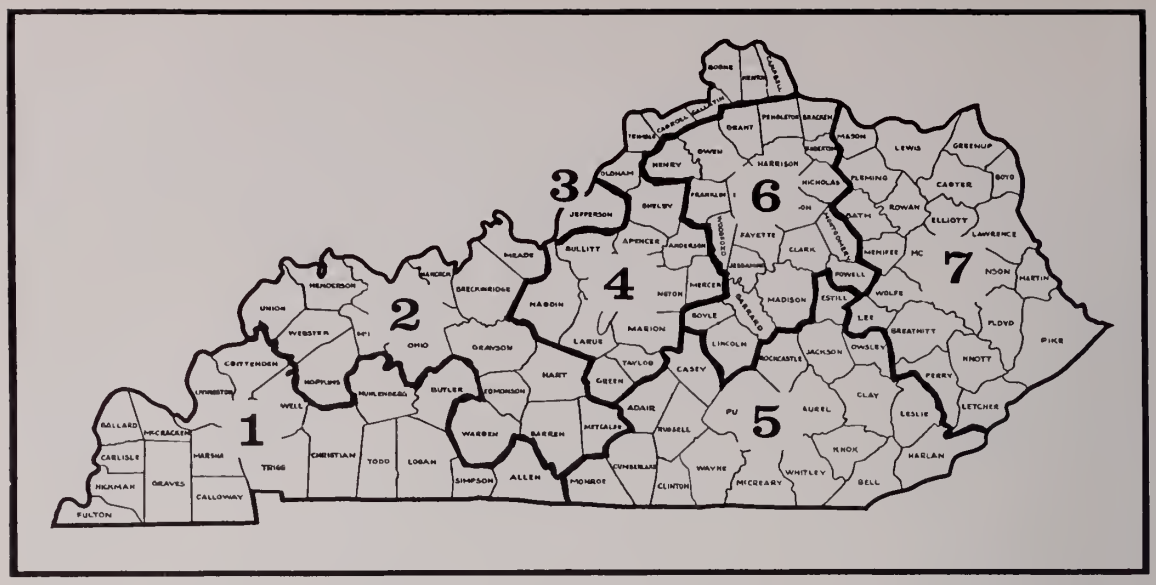
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Doctor Gierlach was engaged in private practice of radiology in Lexington before his clinical appointment and Doctor Hanson previously served as chief resident in radiology at Boston Children's Hospital.

Hershell B. Murray, M.D., West Liberty, has been added to the executive committee of the U. of K. Board of Trustees succeeding J. Stephen Watkins, Lexington, whose term expired.

U. of L. Appointments

U. of L. School of Medicine

The University of Louisville School of Medicine has made several appointments to its faculty.

Arnold Warren Johnson, M.D., has been named assistant professor of medicine.

A. Evan Overstreet, M.D., has been appointed in-assistant professor of medicine.

Arch Evan Cole has been reappointed as professor of anatomy.

The following promotions have been announced by the School: John S. Harter, M.D., to professor of thoracic surgery; George I. Uhde, M.D., to associate professor of otorhinolaryngology; Harold E. Kleinert, M.D., and Condict Moore, M.D., to associate professors of surgery; Herbert Ransdell, Jr., M.D., to associate professor of thoracic surgery.

Fred Stanley Pipkin, M.D., has resigned as instructor in child health and Lewis F. Cook, as lecturer in hospital administration.

Sheppard M. Walker, professor of physiology, has been granted a six months' leave of absence to accept a fellowship for study in England and other parts of Europe.

Among gifts and grants received by the U. of L. are $12,000 from the WHAS Crusade for Children for the Child Psychiatry Study Center; $1,200 from Oscar W. Thompson, Jr., M.D., Medical School alumnus, to the Dental School in honor of his father, a Dental School graduate, to be used for loans to students, particularly those from eastern Kentucky; $792 from various donors for a Medical School scholarship honoring the late Edmund K. Hall, professor of anatomy; $201 from various donors for leukemia research in memory of Mrs. Louis M. Loeser.

Arik Mehmet, M.D., has been named instructor in psychiatry at the U. of L. School of Medicine; Edgar Allan Moes, M.D., instructor in medical psychology in the Department of Psychiatry, and Kenneth Haller McCrocklin, instructor in surgery.

Norman Blaine Hasler, M.D., instructor in medicine, and Joseph A. Little, M.D., associate professor of pediatrics, have resigned. Doctor Little has taken an appointment at Vanderbilt University.

J. Alex Haller, M.D., assistant professor of surgery and Price fellow in surgical research, has been given a leave of absence from the Medical School from October 1, 1962, to March 31, 1963 to study organ transplantation at the Wistar Institute at Philadelphia.

The Medical School has received 60 shares of Babcock Wilcox Company stock from Mr. and Mrs. I. B. Wershaw for research in dermatology.

Three scholarships in medical technology will be offered in nationwide competition by the University of Louisville, according to William M. Christopherson, M.D., director of curriculum of medical technology. They will provide for three years of instruction at the U. of L. and a year's training in the Medical School and $600 expenses each semester. Funds are provided in a General Electric Foundation grant.



Courtesy, The Louisville Times

At the April 2 open house marking the 125th anniversary of the founding of the Medical Library of the University of Louisville School of Medicine. Left to right, Miss Joan Titley, librarian; Miss Blake Beem, librarian from 1937 to 1961, and Doctor Philip G. Davidson, U. of L. president.

U. of L. Medical Library Marks 125th Birthday

The Medical Library of the University of Louisville and Jefferson County Medical Society celebrated the 125th anniversary of its founding with an open house April 2 from 5 to 7 p.m. The open house recreated the custom set up in the original by-laws of the University (1846) that the Board of Trustees appoint a committee to "examine the Library on the first Monday in April."

U. of L. President Philip G. Davidson extended a special invitation to the present board of trustees.

Over 50 members of the medical profession and friends of the Library attended. Exhibits included books from the original library; books owned by members of the early faculty and books given to the Library by the early faculty. The manuscript minutes of the first Board of Trustees and the pages containing the by-laws relating to the Library were on display.

The preliminary plans for the new Medical Center Library were shown. It will house 150,000 volumes in approximately 40,000 square feet and will be located in the block now containing the new Medical-Dental Research Building.

A facsimile of the first few pages of the Catalogue of the Library of 1847 with a brief history of the founding of the Library was given to each guest.

Miss Blake Beem, librarian from 1937 to 1961, presided over the guest book.

Members of the combined Library Committee, Oscar E. Block, Jr., M.D.; Martin H. Boldt, M.D.; Eugene H. Conner, M.D.; S. Spafford Ackery, M.D., David W. Kinnaird, M.D., and Robert Levy welcomed the guests and Mesdames Ackerly, Boldt, Conner and Kinnaird served.

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1 Ford, R. A., and Blanchard, K. Journal-Lancet 78:185, 1958.

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First Conference on Poisons Set for May 23

The First Kentucky Conference on Poisons and Poison Control has been set for May 23 in the Student Union Building at the University of Kentucky at Lexington. The conference is sponsored by the Kentucky Poison Control Program in association with the Kentucky State Department of Health and the U. of K. College of Pharmacy. It is also being cosponsored by the Kentucky Academy of General Practice and has been submitted for Category 1, approval for four hours of credit.

Arnold C. Williams, M.D., Lexington, represents the Kentucky State Medical Association on the executive committee of the Kentucky Poison Control Program.

At the morning session professors of the College of Pharmacy, the College of Medicine and the College of Agriculture will discuss: "The Unnatural History of Poisoning"; "Toxic Potential of Chemical Specialties"; "Bone Marrow Reactions to Drugs"; "Veterinary and Agricultural Aspects of Poisoning." "The Role of the Laboratory in the Investigation of Poisoning" will be discussed by Jacob Cholak, University of Cincinnati, and "The Organization and Operation of Poison Control Programs" by H. L. Verhulst of the U. S. Department of Health, Education and Welfare.

In the afternoon following presentation of "A Predictive Test for Hypersusceptibility to Drugs and Chemicals" by H. E. Stockinger, U. S. Public Health Service, there will be panel discussions on the following subjects: "Medical, Dental, Veterinary and Pharmaceutical Aspects of Accidental Poisoning"; "Organization and Operation of Poison Information Centers"; "Industrial and Safety Aspects of Accidental Poisoning"; "Public Health Aspects Accidental Poisoning."

Doctor Wilson Serves in Haiti

Charles F. Wilson, M.D., Pikeville, ophthalmologist, and Mrs. Wilson recent spent a month at Port DePaix on the island of Haiti where Doctor Wilson was able to work toward providing special medical care in an area where such care had been unavailable. Focus, Inc., organized by Doctor Wilson and eight other eye specialists, and under whose auspices he made the stay in Haiti, is pledged to setting up a program of eye care in all underdeveloped areas in the Western Hemisphere.

The entire expense of Focus is borne by the participating physicians.

AMA News Quotes KSMA Piece

The AMA News of April 2 used, in part, material from the story about the study group of the Jefferson County Medical Society which was originally carried in the March issue of The Journal of the Kentucky State Medical Association. The story points out that the program has led to the "development of an effective team of speakers on socio-economic and political issues relating to the medical profession."



Pictured at the 102nd annual meeting of the Kentucky Dental Association, left to right, E. J. Buechel, D.D.S., Louisville, delegate to the American Dental Association; R. M. Justice, D.D.S., Ashland, president of the Kentucky Association, and George T. Higginson, D.M.D., Morganfield, president-elect.

Kentucky Dentists Elect New Officers in April

Dr. George Higginson, Morganfield, was named president-elect of the Kentucky Dental Association at its 102nd annual meeting at Louisville April 1-4. Dr. R. M. Justice, Ashland, was installed as president.

Other new officers are: first vice president, Dr. John J. Gavingan, Ashland; second vice president, Dr. Maurice Bolton, Louisville; delegate to the American Dental Association, Dr. E. J. Buechel, Louisville; alternate ADA delegate, Dr. C. A. Draper, Madisonville; librarian, Dr. Ernest Ellison, Louisville sergeant at arms, Dr. Hal Arnett, Louisville.

Doctor Higginson was graduated from the Louisville Dental College in 1946. He served as president of the West Central Dental Society and was a member of the board of KDA for three years.

Doctor Rowntree Heads Session of Industrial Medical Assn.

Gradie R. Rowntree, M.D., Louisville, presided over sessions of the 47th annual meeting of the Industrial Medical Association at Chicago the week of April 10 as the president of the Association. Doctor Rowntree is a past president of the Jefferson County Medical Society; currently chairman of the Louisville and Jefferson County Board of Health and is a professor of occupational medicine at the University of Louisville School of Medicine.

William H. Bizot, M.D., Louisville, presented a paper on "Tetanus in Industry" at the meeting. Doctor Bizot is an associate in surgery at the U. of L.

Physicians, dentists and nurses from all over the country attended the three-day American Industrial Health Conference, encompassing the annual meetings of the medical group, the American Association of Industrial Nurses and the American Association of Industrial Dentists.

Doctor McCarty To Get Award

A. Clayton McCarty, M.D., Louisville, retired internist, has been chosen to receive the 1962 Dis-Ditinguished Alumnus Reward of the University of Louisville Hospitals. To be eligible for the Award a physician must have had an internship or residency in one of the hospitals in the U. of L. teaching program.



Doctor McCarty

The Award has been given for the past two years: In 1960 to Glen Spurling, M.D., Louisville, and in 1961 to R. Arnold Griswold, M.D., Louisville. The presentation of this year's Award will be made at the annual dinner meeting of the U. of L. Hospitals Alumni Association at the Medical Arts Building June 7.

Hoyt D. Gardner, M.D., Speaker At Two Indiana Sessions

Hoyt D. Gardner, M.D., Louisville, was a speaker at two meetings in Indianapolis April 4, sponsored by the Student American Medical Association Chapter of the School of Medicine of the University of Indiana.

At the afternoon session, Doctor Gardner addressed the medical school students and outlined the history of legislation—passed and proposed—in the field of medical care. His discussion outlined the subject from the past all the way to the present King-Anderson legislation proposed in the present session of the Congress. He discussed the present Kerr-Mills law and its implementation in the several states.

In the evening, Doctor Gardner and Joseph E. Palmer, administrative assistant for the Indiana State Medical Association, on one side, debated with Mrs. Inez Berghtel, executive director Indiana Chapter of the American Nurses Association, and Morton Leeds, head of a large Indianapolis home for the aged and holder of a Ph.D. degree in Sociology. The subject for the debate: "Medical Assistance to the Aged—How Should It Be Financed?"

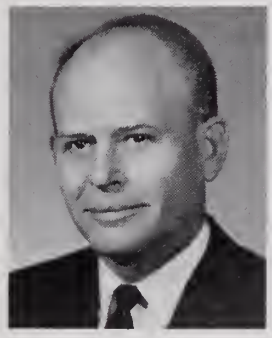
The latter two argued in favor of the Kennedy Administration's plan for medical care to the aged through Social Security as provided for in the proposed King-Anderson Bill. Doctor Gardner and Mr. Palmer took the opposing side of the issue, and pointed out that medical care under the federal government would be subject to manipulation by bureaucracy; would cause over-utilization; that it would be needlessly expensive, and that the proposed plan of the Administration is not only politically-inspired but is needless at the present time since private programs plus the already implemented Kerr-Mills Law are adequately handling the problem.

Survey Units at Fairgrounds

The mobile units of U. S. National Health Survey being conducted by the Department of Health, Education and Welfare are at the Fair and Exposition Center, Louisville. Examinations began April 23 and will continue through the middle of May. John Symond, M.D., is the officer in charge.

Otis Wheeler, Louisville, To Head Ky. Hospital Group In 1963

Otis L. Wheeler, director of Jewish Hospital, Louisville, was named president-elect of the Kentucky Hospital Association at the March 19-22 meeting of the Association at the Kentucky Hotel, Louisville. Mr. Wheeler's term as president will begin in March 1963.



Mr. Wheeler

Col. Robert E. Selwyn, administrator, Harlan Memorial Hospital, Harlan, Ky., is the new president, succeeding Homer D. Coggins, administrator, Central Baptist Hospital, Lexington.

Elected trustees are: Donald G. Shropshire, administrator, Eastern State Hospital, Lexington; William H. Kimble, T. J. Samson Hospital, Glasgow; Sister Dorothy Maria, S.S. Mary & Elizabeth Hospital, Louisville; Robert W. Walker, State Tuberculosis Hospital, Paris, and W. Leon Hisle, Berea College Hospital, Berea.

Malcolm H. Black, administrator of the District 6 State Tuberculosis Hospital, Glasgow, received the annual William A. Wyckoff Award established by the Western Kentucky Hospital Conference. Mr. Black was praised for his work for the Conference and the State Association. He also received a past president's certificate from the State Association.

Doctor Maddox Honored

Paul F. Maddox, M.D., Campton, received the Physician's Award for 'exceptional contributions by facilitating employment of the handicapped," at the annual luncheon meeting of the Governor's Commission on Employment of the Handicapped in Louisville April 20.

Doctor Teague Named

Russell E. Teague, M.D., Kentucky commissioner of health, has been named to a 10-man medical consulting group to advise the U. S. Department of Health, Education and Welfare. The position, which is nonpaying, is concerned with setting up standards for a wide variety of medical-care programs, both government and private, according to Doctor Teague.

Speakers For Ob-Gyn Meeting Told

Speakers for the 15th annual meeting of the Kentucky Obstetrical and Gynecological Society, May 24-26, at Gabe's Restaurant in Owensboro, will include: Carl Huber, M.D., Indianapolis: Ralph Reis, M.D., Chicago, and W. H. Missildine, M.D., Columbus, Ohio.

Members of the Society will also participate in the program, according to Charles E. Hornaday, M.D., Owensboro, Society secretary. There will be entertainment in the evenings and special plans for the wives attending.



Six physicians with a total of 330 years of service in the profession, were honored by the Women's Auxiliary at a dinner at Owensboro March 28, as a prelude to "Doctors Day" March 30. Plaques were presented to the doctors by Gaithel L. Simpson, M.D., Greenville, president of the Kentucky State Medical Association. Shown here seated, left to right, William B. Negley, M.D., Owensboro; Oscar Allen, M.D., McHenry; Cicero M. Rice, M.D., Owensboro; William L. Tyler, Sr., M.D., Owensboro. Standing left to right, E. Dargan Smith, M.D., Owensboro; Doctor Simpson, Otway W. Rash, Owensboro.

"Doctors Day" Marked in Kentucky With Observances

"Doctors Day" was proclaimed and observed throughout Kentucky in many special observances March 30.

Doctors Day is a project of the Women's Auxiliary of the Southern Medical Association and March 30 is the date chosen for the observance as it marks the date in 1842 when Crawford W. Long, M.D., Georgia physician, first used ether as an anesthetic agent in a surgical operation. The Day is observed in about 16 southern states.

In Fayette County the Women's Auxiliary paid special tribute to the late Richard Gill Elliott II, Lexington pediatrician and past president of the Kentucky State Medical Association. His memory was honored by presentation of a cash gift to the Baby Health Service at Lexington of which he was a staff member at the time of his death.

At Owensboro, special tribute was paid to six doctors each of whom has contributed more than 40 years of service to the profession.

Otway W. Rash, M.D., Owensboro, on April 6 marked 65 years in the practice of medicine. Doctor Rash was born in 1876 and was graduated from the Bellevue Hospital Medical College, New York City, in 1897.

The Medical Auxiliary in Mason County honored Mason County Medical Society members at Hayswood Hospital where they gave doctors making their rounds red carnation boutonnieres for their lapels. Later in the day, the physicians were served doughnuts and coffee.

The Auxiliary of the Henderson County Medical Society served free coffee and doughnuts to doctors at Methodist Hospital and presented each with a boutonniere of red carnations. The Doctors were also honored with a dinner the evening of March 29.

Doctors Day was observed in Paducah by members of the McCracken County Medical Society and Auxiliary.

In Corbin, Mayor Ed Peace issued a special proclamation and the Whitley County Medical Society auxiliary honored Society members.

The Pulaski County Medical Society women's auxiliary honored the doctors of the county with a dinner in the dining room of the Somerset City Hospital. Carl Norfleet, M.D., was honored as the first chief of staff of the hospital and a large oil portrait of him was presented and hung in the hospital lobby. Red carnations, used as a centerpiece on the table, were later placed in the office of the hospital in memory of the late A. A. Weddle, M.D.

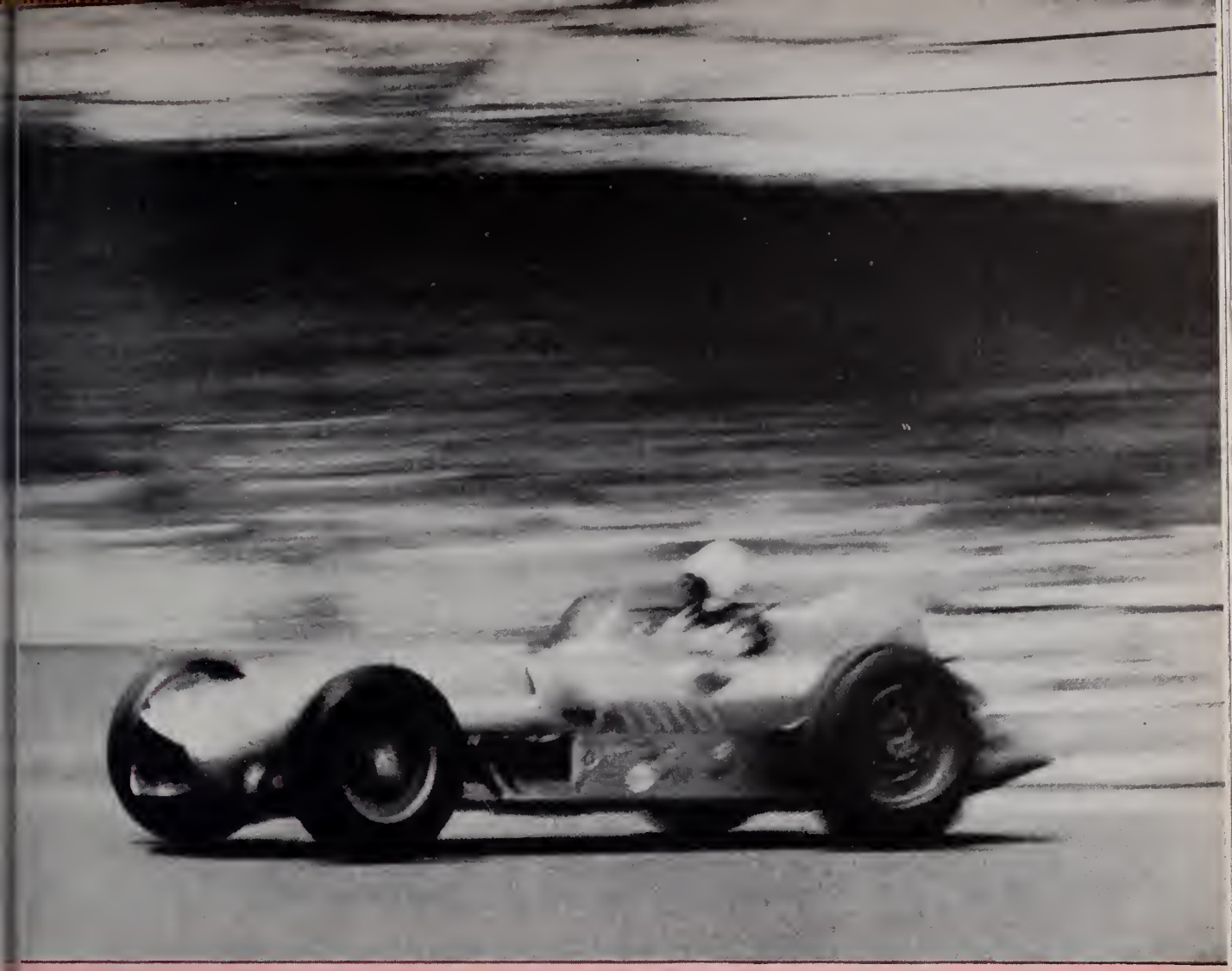
At London, the Laurel County Medical Auxiliary honored physicians of the county with a dinner.

Doctor Martin Wins $1000 Award For Article

Homer B. Martin, M.D., Louisville, Ky., was one of the two winners of the Ross Awards of $1,000 each for his article published in the December 1961 issue of GP, the Journal of the American Academy of General Practice. The title of his paper was: "Specific Diagnosis of Psychoneuroses." The award was given at the annual meeting of the Academy at Las Vegas, Nev., April 11.

Doctor Martin recently was named director of general practice teaching at the University of Louisville School of Medicine in the section on community health.

Carroll L. Witten, M.D., Louisville, was reelected speaker of the House of Delegates of the Academy.



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An aerial view of the University of Kentucky Medical Center, Lexington, showing the hospital in the immediate forefront; the outpatient area to the center left; the ambulant wing immediately behind the outpatient area, and the dental sciences wing parallel to the ambulant wing. In the middle of the Center is the medical sciences building. The view is from the Nicholasville Road.

SMA To Meet at Miami Beach

The Southern Medical Association will hold its annual meeting November 12-15 at the Fontainebleau Hotel, Miami Beach. Applications for exhibits may be obtained from George F. Schmitt, M.D., chairman of the Scientific Exhibit Committee, 30 S.E. 8th St., Miami.

Sam A. Overstreet, M.D., Louisville, has been named councillor-elect for Kentucky for the SMA. Doctor Overstreet will succeed the present councillor for Kentucky, J. Duffy Hanock, M.D., Louisville.

Medical Women's Association To Hold Brunch at Chicago

The American Medical Women's Association will hold a brunch at 11 A.M. Sunday, June 24, at the Essex Inn, Chicago, during the Annual Meeting of the American Medical Association. The Women's Association is inviting all women physicians present at the Annual Meeting to attend this session.

"Medical Woman Power—Can It Be Used More Effectively" will be discussed by a panel with audience participation.

The coupon below may be filled out by those women physicians who wish to attend the brunch.

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1790 Broadway, N.Y. 19, N.Y.
I will accept your invitation to the brunch on June 24 at the Essex Inn in Chicago, Ill.
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Meetings For May

The Kentucky Surgical Society meets May 25-26 at the Netherlands-Hilton Hotel, Cincinnati.

The 11th Scientific Assembly of the Kentucky Academy of General Practice is at the Kentucky Hotel, Louisville, May 9-11.

The Kentucky Obstetrics and Gynecological Society will be in session May 24-26 at Gabe's Restaurant, Owensboro.

Kentucky Medical Assistants Elect First Slate of Officers

Louise Hawkins, Louisville, was elected president of the Kentucky State Association of Medical Assistants at the second meeting of the group at the King's Daughters Hospital, Frankfort, April 15. The first meeting of the Association was held at the Norton Memorial Infirmary, Louisville, March 11, 1962, when a draft of the constitution and by-laws was adopted.

At the second meeting the constitution and by-laws were adopted and the following additional officers elected: President-elect, Mary Crump, Frankfort; vice-president, Dorothy Downs, Louisville; recording secretary, Catherine Corbin, Louisville; treasurer, Phoebe Faust, Louisville; directors, Jackie Wreen, Louisville, and Rose Ueithi, Frankfort. Bettye Fisher, Evansville, Ind., immediate past president of the American Association of Medical Assistants, installed the officers.

Organization of the KSAMA was officially sanctioned by the House of Delegates of the Kentucky State Medical Association in September 1961 on the recommendation of the Council on Communications and Public Service.

Digest of the Minutes of the KSMA Board of Trustees

Board of Trustees

Wyatt Norvell, M.D., Chairman

Louisville **March 29, 1962**

Following the call to order and announcements, along with the approval of the minutes of the last meeting, the Board heard the President's report and the report of the Headquarters Office.

As a special item of business, the Board expressed its appreciation to the Medical Research Foundation, George F. Brockman, M.D., Greenville, president, for a substantial gift that was made to the Association to assist in providing quarters for the Rural Kentucky Medical Scholarship Fund in the new Headquarters building.

The Board then accepted a recommendation of the KSMA Committee on Public Health that "every physician who sees a child under 12 months of age, or at any age for that matter, shall see that the child has been immunized against diphtheria, pertussis, tetanus, polio and smallpox and that all local health departments encourage persons who are able to obtain such immunization from their private physicians."

The Board then heard reports made from representatives who attended the meeting on health care benefits and Social Security in Chicago and the mental health conference in Chicago earlier this year. It was recommended that digests of these reports be carried in The Journal of KSMA.

The Board then acted unfavorably on a proposal of a pharmaceutical company to contribute $250 to the expense of a guest speaker at the Annual Meeting in lieu of exhibiting in the technical exhibit hall at the annual session.

The Board next heard Clyde C. Sparks, M.D., chairman of the KSMA Technical Advisory Committee on Indigent Care, discuss certain problems faced by the committee. It then clarified the Association's policy with respect to its views on matters relating to out-patient care in hospitals.

Members of the Board were acquainted with the conference to be held in St. Louis April 14-15, sponsored by the AMA Council on Medical Service and the National Association of Blue Shield Plans.

The Board was then brought up to date on the status of the King-Anderson Bill and other matters before Congress with special interest to medicine. A summary of bills with medical and health implications introduced into the 1962 Kentucky Legislature and what happened to them was given to the Board.

The Board acted favorably on a recommendation from the Council on Legislative Activities that it recommend one of its members active in legislative matters to the Awards Committee for consideration as a nominee for the Distinguished Service Medal.

A recommendation that the Governor be thanked by the Board for his support of health objectives of the Association was unanimously passed.



At Senior Day, March 19, at the Medical Arts Building: Back row, left to right, David W. Kinnaird, M.D., Louisville, Jefferson County Medical Society chairman; Everett H. Baker, M.D., Louisville, president of the Society; Carl Cooper, Jr., M.D., Bedford, Kentucky State Medical Association chairman. Front row, left to right, J. Murray Kinsman, M.D., Louisville, dean of the University of Louisville School of Medicine; Hebbel E. Hoff, M.D., Houston, Tex., Baylor University College of Medicine, featured speaker, and David M. Cox, M.D., Louisville, KSMA president-elect.



Leaders of panel discussion groups at Senior Day, March 19, at the Medical Arts Building are pictured here: Back row, left to right, Hoyt D. Gardner, M.D., Louisville; John W. Ratliff, Jr., M.D., Lebanon; Carl H. Scott, M.D., Lexington; Paul E. Lett, M.D., Lancaster; Orson P. Smith, Jr., M.D., Louisville; Garnett J. Sweeney, M.D., Liberty; John C. Quertermous, M.D., Murray; Durrett C. Bennett, M.D., Beaver Dam. Front row, left to right, Jack L. Chumley, M.D., Louisville; Donald Chatham, M.D., Shelbyville; Carl Cooper, Jr., M.D., Bedford, and Wyatt Norvell, M.D., New Castle.

The chairman of the KSMA Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., was introduced and asked to present the recommendation of the Commission—the primary reason for the calling of this meeting. The recommendation was that the KSMA Board of Trustees accept and support the proposed joint program for medical care for the aged as announced earlier in the year by the AMA and the National Association of Blue Shield Plans.

Following approximately two hours of discussion, the Board passed a motion without dissenting vote that it approve the recommendation of the Advisory Commission and present it to a full meeting of the KSMA House of Delegates.

In another action the Board recommended that the delegates, county society secretaries and legislative key men receive full information and that all county societies be urged to consider this matter carefully before sending their delegates to the special meeting of the House which was set for Thursday April 12.

A recommendation that the U. S. Public Health Service proposal to conduct a highway safety survey in Kentucky be approved was adopted.

It was decided that the next meeting of the Board would be held at 10 a.m. Sunday, May 20, in the Board Room of the Blue Cross-Blue Shield Building, just prior to the dedication ceremonies of the new KSMA Headquarters Building at 2 p.m. that afternoon.

Ky. Surgeons Speak at Memphis

Four Kentucky surgeons were participants on the program of the American College of Surgeons meeting at Memphis, Tenn., the week of March 26. Rudolph J. Noer, M.D., professor and chairman of the Department of Surgery at the University of Louisville School of Medicine, participated in a panel on gastrointestinal bleeding.

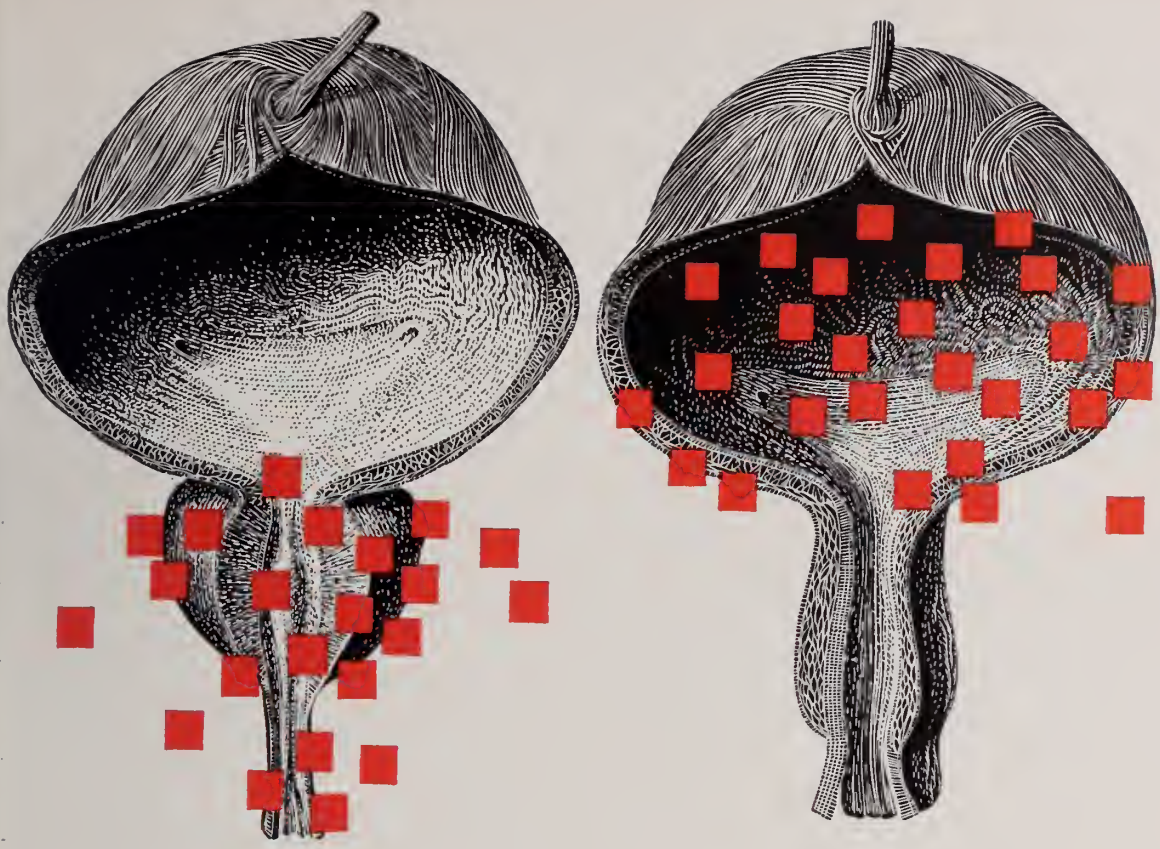
Ben Eiseman, M.D., chairman of the Department of Surgery at the University of Kentucky College of Medicine at Lexington, discussed the management of surgical patients on steroids, anticoagulants and antibiotics. Laman A. Gray, M.D., U. of L. associate professor of obstetrics and gynecology, spoke on congenital anomalies of the lower urogenital tract and the gastrointestinal tract. Francis M. Massie, M.D., Lexington surgeon, discussed neoplasms of the breast.

More Than $816,012,000 Paid Out By Blue Cross Plans in '61

More than $816,012,000 was paid by the 75 Blue Shield Plans for care rendered during 1961, according to the National Association of Blue Shield Plans in an April 16 announcement. In the same period the plans recorded an enrollment gain of more than 2,037,000 persons.

Total membership in North America's Blue Shield plans at the close of 1961 stood at 49,122,164, representing 25% of the total population of the United States and just over 15% of the total Canadian population.

Payments in 1961 to the medical profession on behalf of members represented nearly 89% of the total income of all the plans and less than 10% of total income was used for administrative expenses. Payments to doctors rose from $165,000,000 in 1951 to the 1961 figure of over $816,012,000.



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OPPORTUNITIES

From The

KSMA Postgraduate Medical Education Office

Upjohn Company Makes Gift

The Upjohn Company, Kalamazoo, Mich., pharmaceutical firm, has made a grant of $500 to the Postgraduate Medical Education Office of the Kentucky State Medical Association, to be used for the support of its postgraduate education program.

The Kentucky Postgraduate Medical Education Fund was ruled exempt from the federal income tax on November 29, 1961, making contributions to the fund deductible by the donor. Gifts or transfers to the Office are deductible for federal estate and gift tax purposes.

In Kentucky

MAY

15	**Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.
17	Benjamin Felson, M.D., "Fundamentals of Cardiac Roentgenography," University of Kentucky Medical Center, Lexington, Ky., 7:30 p.m.
17-18	Kentucky Obstetrical & Gynecologic Society, Owensboro, Ky.
22	**Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.
29	**Postgraduate Course, PEDIATRICS,** Louisville Children's Hospital, 9:30 a.m. through 12:30 p.m., each Tuesday morning, Louisville, Ky.

JUNE

7	KAGP Seminar, Harrodsburg, Ky.
14	KAGP Seminar, Henderson, Ky.

JULY

12	KAGP Seminar, Country Club, Paintsville, Ky.
19-20	KAGP Seminar, Kentucky Dam Village, Gilbertsville, Ky.

Surrounding States

MAY

14-17	American Urological Association, Philadelphia, Pa.
20-25	National Tuberculosis Association, Miami, Fla.
23-25	Postgraduate Course, **Psychiatry,** University of Tennessee College of Medicine, Memphis, Tenn.
24	Postgraduate Course, **Inter-Relationships of the Mental Hospital and the Psychiatric Problems of Medical Practice,** Vanderbilt University School of Medicine, Nashville, Tenn.
28-June 2	American College of Radiology, Denver, Col.
28-30	American Ophthalmological Society, Hot Springs, Va.
31-June 2	American Gynecological Society, Hot Springs, Va.

JULY

22	Symposium, **Inflammation, Mental Depression,** Blue Ridge Chapter of General Practice, Hotel Roanoke, Roanoke, Va.

Is your group holding a meeting or sponsoring a speaker or an activity that you believe would interest others in the profession?
Are you looking for a speaker for your next monthly session or annual meeting?
We can help—if you will get in touch with the Postgraduate Office of the Kentucky State Medical Association, 3532 Janet Avenue, Louisville 5, Ky. Or phone us: GL 4-6324.

Pediatrics Course Well-Attended

Approximately 35 physicians are attending the annual Postgraduate Course in Pediatrics at Children's Hospital, Louisville, which runs through May 29. The course, which opened April 10, is being presented by the Department of Pediatrics of the University of Louisville School of Medicine and is sponsored by the Kentucky Chapter of the American Academy of Pediatrics, the Kentucky Academy of General Practice and the Office of Postgraduate Education of the Kentucky State Medical Association.

Student AMA

University of Kentucky

Ballard Wright Elected President

The Student American Medical Association Chapter at the University of Kentucky has elected its officers for 1962-63. They are: President, Ballard Wright; vice president, Bill Hall; secretary, Mrs. Shirley Moore and treasurer, Max Kimball. Advisor for the group is Beverly Mead, M.D., Department of Psychiatry.

President Ballard Wright and the immediate past president, Joe Christian, are attending the national convention of SAMA at Washington, D. C., May 9-12. The Kentucky State Medical Association is providing the necessary funds for the trip. In the next issue of The Journal I will discuss our activities while at the convention.

Next September we will greet our third class here at the University of Kentucky. We are now making plans to get our membership drive underway with a rush week. With an ever-increasing student body here at the U. of K., our Chapter must assume a more integral part in student activities.

We have set up committees on writing a constitution; the feasibility of participating in a joint project with the College of Law, and on the enlisting and maintaining of student interest in SAMA.

In all this we are attempting to relate ourselves to our School and our problems, otherwise we will be another paper organization. We understand that this is not an easy task, but it is a challenging one, for we are not shackled by tradition. We are limited only by the extent of our vision.

Ballard D. Wright, President
University of Kentucky SAMA

University of Louisville

Federal Aid to Students

The subject of federal aid to medical students, in the form of scholarships, will constitute a heavy majority of the discussion and action at the national convention of the Student American Medical Association being held this year May 9-12 at Washington, D. C. In the very midst of the city which houses our governmental representatives, and from which come our laws, the gathering of medical students will undertake to determine a steadfast position on this issue.

National SAMA in its policy, as most other organized groups of medicine, is attempting to prevent any governmental support of medical students by way of scholarship funds on the basis that such scholarship recipients will look with more favor on other federal designs for and upon medicine—to wit—more federal control of the entire profession.

The initial thoughts on this question were brought before the House of Delegates at the 1961 convention of SAMA in Chicago. In spite of vigorous opposition, the policy of SAMA on this issue was set forth as stated above. I say, "in spite of vigorous opposition," for there were whole sections of the National SAMA who were in favor of whatever aid they might secure from any source—be it government or otherwise. It is difficult to say that these persons, representing their own schools, were wrong in desiring some alleviation of the strenuous budget placed upon the medical student.

It is the hope of SAMA that students may find private sources—industry, foundations, etc.—which will be willing to offer scholarship support to students, in an effort to offset the need for federal aid. Already SAMA has begun token scholarship programs for summer work, supported by the Sears Roebuck Foundation. Much more than token funds will however be necessary.

It is altogether conceivable that student opinion will run counter to the feeling of the National SAMA and pave the way for the acceptance of federal scholarship aid.

I will not attempt to express the opinion of U. of L.'s Chapter of SAMA on this issue. It is however very likely that our student body would be very eager to obtain whatever scholarship aid is offered. If this is an opening of the dike to the socialization of medicine, then it is very near to becoming a deluge.

Olson Huff, President
University of Louisville SAMA

WASHINGTON NEWS

(Continued from page 448)

inactivated vaccine and the oral vaccine, are available for general use," Doctor Terry said. "Their proper application should accelerate the decline in poliomyelitis and could lead to the early elimination of the disease."

The PHS called for emphasis this year on vaccination of the unimmunized and inadequately protected with one or the other of "these effective vaccines (or a combination so long as there is at least a complete series of either) and also to the initiation of as many well-organized community-wide programs as the supply of vaccines will permit."

The PHS set four priorities in use of the polio vaccines:

1. Vaccination programs in areas threatened with epidemics. The PHS Communicable Disease Center at Atlanta, Ga., will keep on hand supplies of oral vaccine to meet this need.

2. Routine immunization of infants, starting when six weeks old and completed in 12 months.

3. Immunization of pre-school children.

4. Immunization of young adults and parents of young children.

Layson B. Swann, M.D., who has offices at Henderson, Ky., has also set up practice at Corydon on a part-time basis. Doctor Swann was graduated from the University of Louisville School of Medicine in 1936.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1962 Annual Meeting — Kentucky State Medical Association

Columbia Auditorium — **Louisville, Kentucky** — **September 18, 19, 20**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman

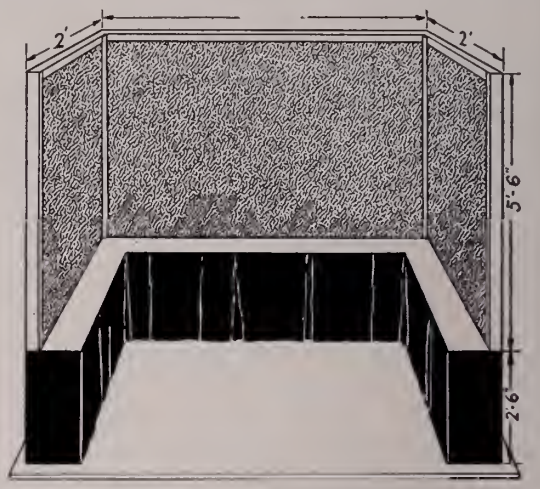
Committee on Scientific Exhibits

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Applications for space should be received before July 1, 1962

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank, not to exceed 100 words, which will be used in the program.)

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.



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Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U.S. PAT. OFF.

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County Society Reports

Fulton-Hickman County

Robert T. Peterson Jr., M.D., was elected president of the Fulton-Hickman County Medical Society, March 12. Other new officers are: Vice-president, John W. Ragsdale, Jr., M.D., and treasurer, Jean A. Poe, M.D., R. Ward Bushart M.D., was named delegate to the KSMA September Annual Meeting. All are from Fulton.

Graves County

Jacob M. Mayer, M.D., was elected president of the Graves County Medical Society March 13. Other new officers are: Vice-president, Jesse W. Page, M.D., and secretary-treasurer, James R. Van Arsdall, M.D. Robert A. Orr, M.D., was elected delegate to the KSMA Annual Meeting. All are from Mayfield.

Madison County

A dinner meeting for the Madison County Medical Society, attended by members and their wives, March 27 was addressed by Hubert C. Jones, M.D., Berea, who discussed Blue Shield-Blue Cross insurance plans for the elderly. John A. Wimberly, M.D., Paint Lick, vice president, presided in the absence of President E. Coleman Whitaker, M.D., Berea.

Pike County

The Pike County Medical Society at its March meeting heard an address by Ballard W. Cassady, M.D., Pikeville, vice president, who discussed the costs of medical care.

He said in part: "It is disturbing to see attempts to deceive the American people in order to put over a politically-inspired measure like the King-Anderson Bill which would force a new tax increase on the working people to pay for medical services, not just for those in need, but for millions who can afford their own medical care."

Medical Society Hears Legislator

Members of the Jefferson County Medical Society were urged to begin "an all-out fight against the whole octopus of galloping socialism," by Congressman Durward G. Hall, M.D., (R), Missouri surgeon, at a meeting of the Society April 15. Doctor Hall called the Administration's medical-care through Social Security plan, "a cruel hoax, a cruel play for votes," and said the already enacted Kerr-Mills medical care program would provide much greater service.

The Society passed a resolution backing the new Blue Shield program for senior citizens, stating the Society's opposition to the federal medical-care plan and urging "all citizens" to voice their objections to it. A copy of the resolution has been sent to Kentucky's congressmen and to President Kennedy.



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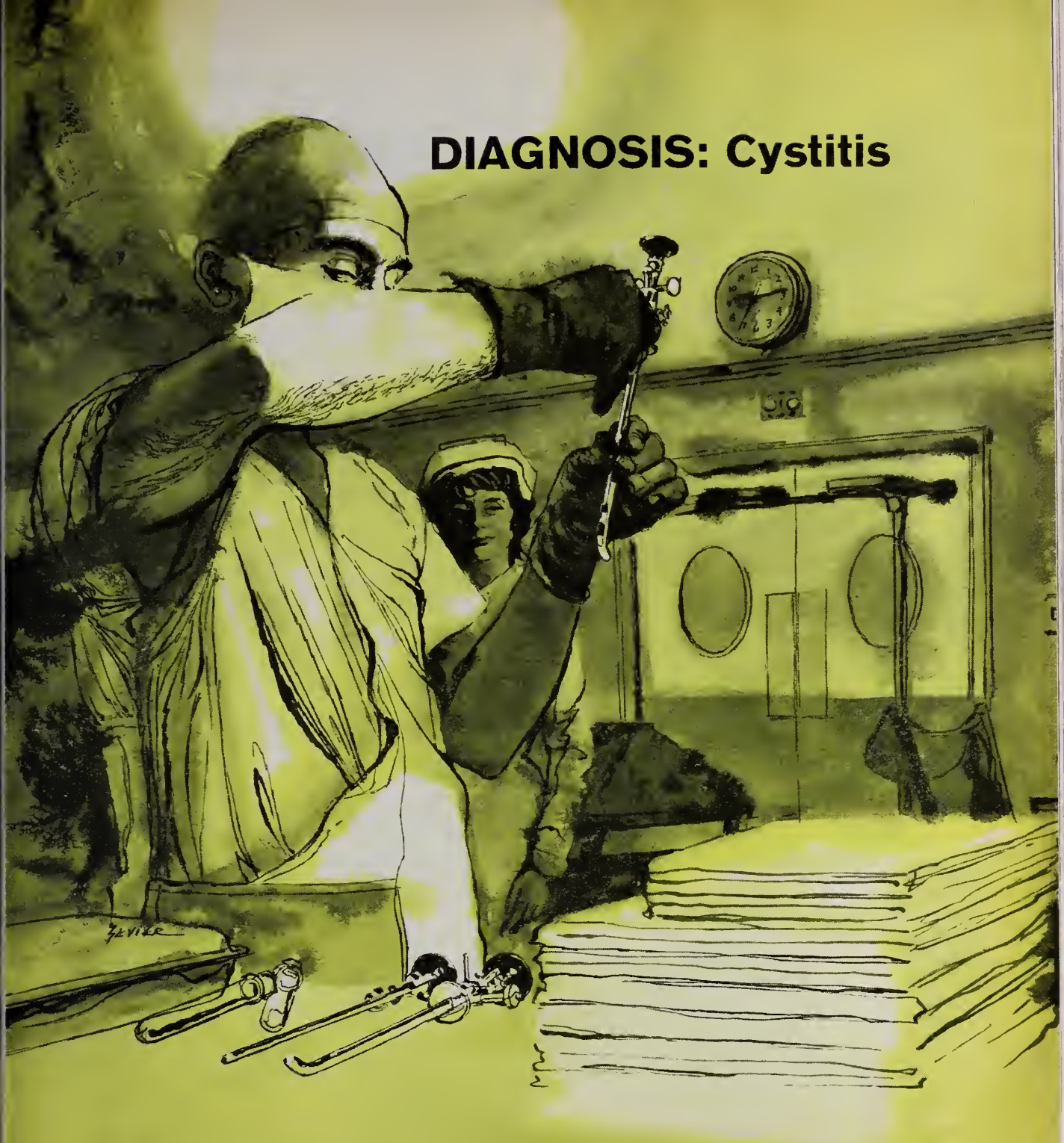
Contact:

W. B. Clark, Jr. M.D.,

Jeffersonville, Indiana

The California College of Medicine, formerly the Los Angeles College of Osteopathic Physicians and Surgeons, has been accredited as a medical school by the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges.

The number of guaranteed-for-life health insurance policies and plans available to persons in or near retirement is increasing at a rapid rate, according to the second edition of a booklet published recently by the Health Insurance Institute. Between July 1961 when the first edition was published and January 1962 when the second was published there has been a 25% increase in the number of policies offered in this field. As of January 1962, 81 companies were providing a total of 157 policies guaranteed for life.



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pHisoAc® Cream dries, peels and masks lesions. Use it with pHisoHex washings to help prevent comedones, pustules and scarring. Contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent.

pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint—and in combination package with pHisoAc Cream.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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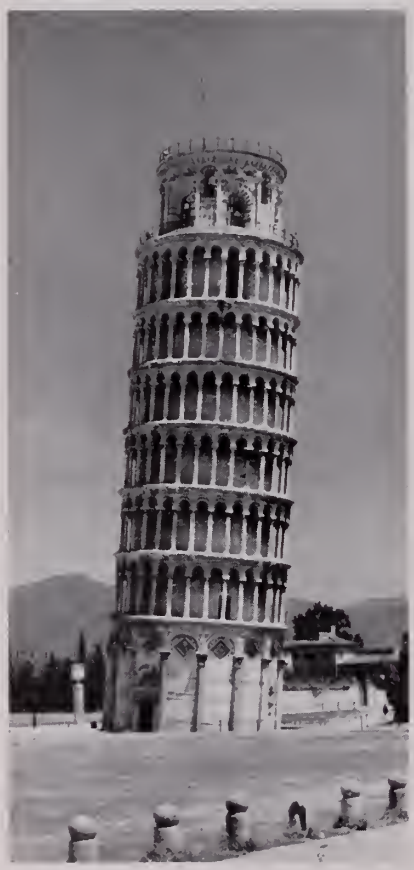


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1. *Methyl-Testerone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No.2, February 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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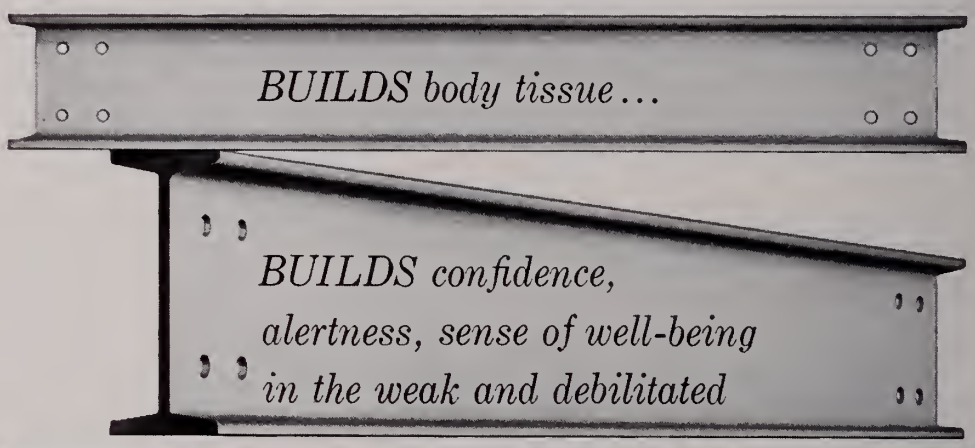
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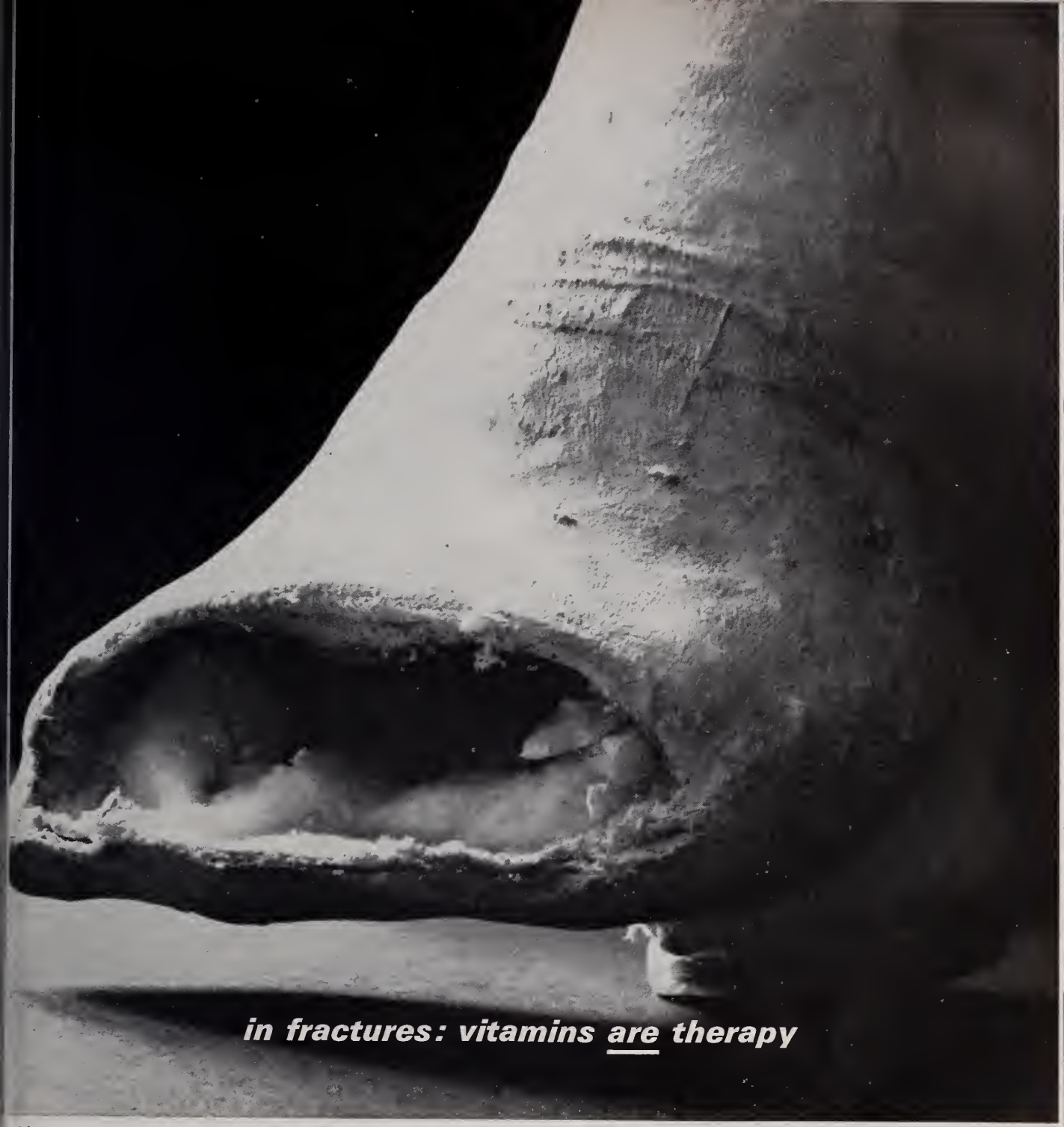
Dosage: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

*animal data

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #102—A 27-year-old white gravida 5, para 4 was hospitalized on the evening of February 27, 1960, in active labor. The patient had not been seen by a physician during her pregnancy.

On admission, a term-sized fetus lay in breech presentation. After four hours, the cervix reached full dilatation and the breech was delivered. There was difficulty in delivering the after-coming head, which proved to be hydrocephalic. A trocar was inserted into the large fontanelle and the head was decompressed, following which a dead female infant was extracted at 11:50 p.m. Following delivery, there was a moderate amount of bleeding. The placenta was delivered intact; the method of expression was not stated on the chart.

Thirty minutes after delivery, the patient presented clinical signs of shock. She was transfused with five pints of whole blood within the next two hours, but there was no improvement in her condition.

Surgical consultation was obtained about three and one-half hours after delivery and immediate abdominal exploration was carried out. A large broad ligament hematoma was encountered retroperitoneally on the left. Ligation of the left internal iliac artery and vein was performed, and the patient's systolic blood pressure promptly became stabilized at 100.

Supracervical hysterectomy was then performed. The ureter on the left side was exposed throughout its entire length. The patient's immediate postoperative condition was good.

On the first postoperative day, the urinary output was 600 cc., but on the second day the output was only 300 cc. despite adequate intake. Impending renal failure was anticipated in view of the antecedent episode of prolonged shock.

Although the patient had been given 13 pints of blood, her hemoglobin was only eight grams. On supportive therapy, the blood urea nitrogen rose steadily reaching 80 milligrams per cent on March 5. Serum chloride and potassium levels were within normal limits.

At 7 p.m. on March 5, the patient transferred to a hospital where an artificial kidney was available. At the time of transfer, the respirations were 20 per minute; the blood pressure 150/90; the temperature 98°, and the pulse 80. The hemoglobin was 9.2 grams (61.3%), RBC 3,108,000 with slight anisocytosis, WBC 10, 3000, 90 neutrophils, eosinophils 1, monocytes 1, lymphocytes 8.

Twenty units of protein zinc insulin were given. The only oral feedings were of rock candy. She seemed slightly confused during the night and was awake most of the time; the total urinary output for the night was 148 cc. The patient was quite restless and attempted to get out of bed on numerous occasions.

On March 7, the patient was more rational and said she was hungry. A copious dark vaginal discharge was noted. The left foot and ankle were cold to the touch.

At 11:15 p.m. the patient had a convulsion; the extremities were noted to be rigid and the pupils were dilated. No blood pressure could be obtained. The patient was placed in an oxygen tent and sodium amytal was administered intravenously. At 11:45 p.m. the blood pressure was 104/?. Three hours after the convulsion, the patient still exhibited some jerking motions of the extremities but was alert. A large amount of bright drainage containing a medium-sized blood clot was obtained by nasopharyngeal suction. Throughout the night, jerking movements continued. The blood pressure was stable at about 120/80.

By 5 p.m. on March 7, the patient was comatose. The respirations were shallow and irregular. Moist rales were present throughout both lungs. The nasopharynx was plugged with mucus.

A drop in blood pressure to 106/94 was noted at 1 a.m. on March 8 and Levophed was added to the intravenous infusion. The patient was cyanotic and exhibited rapid and shallow breathing and a weak and thready pulse. Her condition continued to deteriorate and she died at 2:55 a.m. March 8. Permission for autopsy was not obtainable. The final diagnosis was recorded as renal failure of undetermined cause.

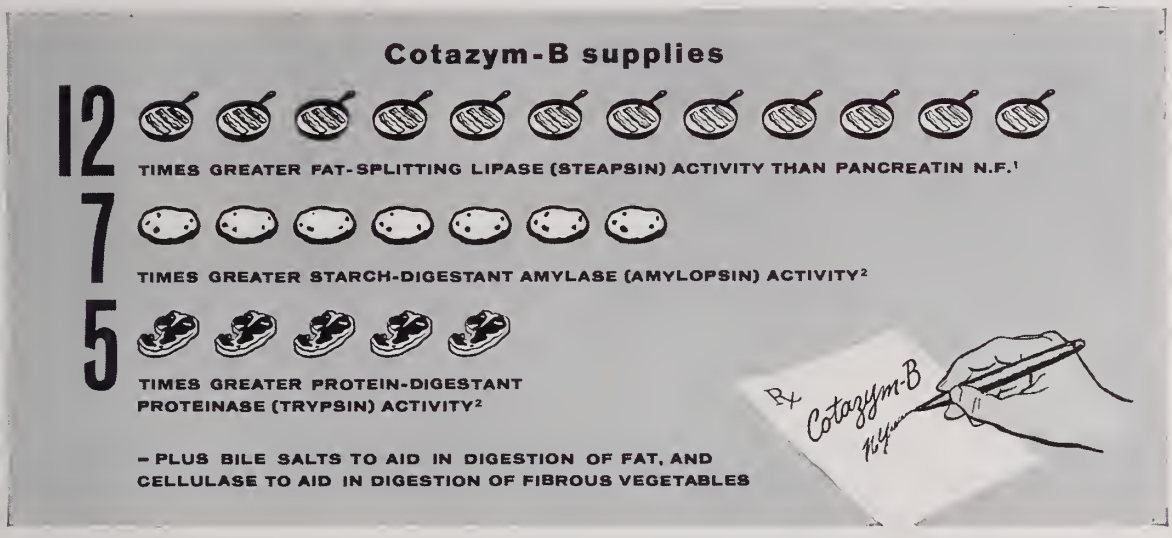
Committee Comments:

The committee thought this a direct obstetric death with preventable factors. The patient was partly responsible since she had not sought prenatal care. The committee believed that exploration of the uterus immediately following the delivery might possibly have averted the serious hemorrhage.

Since signs of hemorrhagic shock followed the traumatic operative procedure, more prompt abdominal exploration might have reduced the amount of blood needed and might possibly have prevented the anuria due to the hypotension.

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Dosage: 1 or 2 tablets with water just before each meal.

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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PUBLIC HEALTH PAGE

The New X-Ray Clinic Service*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

FOR the past several years, the Division of Tuberculosis Control has been operating mobile x-ray survey units. These units have visited each county once a year and stayed from two to five days, on the average, parked usually on the town's main streets. Miniature x-rays have been taken of all comers.

This technique found many new cases of tuberculosis but, as time goes on, the returns are becoming smaller. We have not been reaching the elderly nor the ill but have been x-raying over and over again the same people who are comparatively young and health-conscious; in other words, the segment of the population least likely to have tuberculosis.

Another problem has been the lack of facilities for follow-up of abnormal miniatures found. A miniature film is only a screening technique and is not of diagnostic quality. It is essential that the abnormal miniature be followed by the standard 14x17 film and whatever further investigation that then seems necessary.

The primary responsibility for this follow-up rests on the family physician. However, it often is difficult for him to arrange the necessary investigation. For this reason, we have modified our method of operation since January of this year. Instead of visiting a county once a year, the unit now visits at intervals of one to three months depending on population and case load. Instead of parking on a town's main street, it parks at the health department and we take both miniature and 14x17 chest films.

Thus the Division is now providing to the county health department, the family physician and the patient full chest x-ray facilities at regular and frequent intervals. This permits service to those who have had abnormal miniatures; to known cases, particularly the many inactive cases who need only an annual x-ray, and to the patient referred by his physician.

Large films will be taken on known cases of tuberculosis; those having abnormal miniatures and on suspects referred by their doctors because of chest symptoms. Miniatures will be taken on contacts, food-handlers, other occupational groups and the general public.

The scheduling is experimental at first but when we know the need of the individual counties better, we hope to be able to establish a permanent schedule on a "second Tuesday" basis and this will be sent to all physicians.

Abnormal miniature films are reported to the family physician and the patient is informed by letter that he should get in touch with his doctor.

The responsibility for carrying out the necessary follow-up remains with the physician. The county health department takes action only if the patient has no physician or if the attending doctor requests it.

If the patient is found to have active tuberculosis, the case should be reported in the usual way by the attending physician.

The follow-up reports to the State Health Department are important in many ways in evaluating the program and we are grateful to the many physicians who have cooperated so well in sending in these reports. It helps us greatly if the physician makes sure that the patient's x-ray number is on the report.

We hope that the improved x-ray facilities will provide better service to the patient and be of help to the physicians of Kentucky.

**This article was prepared by M. Stuart Lauder, M.D., C.M., director, Division of Tuberculosis Control, Kentucky State Department of Health, Frankfort, Ky.*

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Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L. : M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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Answers To Questions About Your BLUE SHIELD

Q. Why can't Blue Cross-Blue Shield pay for materials and supplies the physician uses in office or clinic to treat patients? To get this service covered I have to take the patient to the emergency room of a hospital and this encourages more use of Blue Cross.

A. Blue Shield was designed to pay the doctor an indemnity allowance for rendering a professional service, and materials used were considered in setting the allowance. Blue Cross was designed to pay for hospital-type services when it is medically necessary for services to be used and cannot legally pay for services provided anywhere but in a hospital, and members are not paying in their Blue Cross dues for those not provided in a hospital.

Q. Is the First Day In-Hospital Medical Rider available to everyone?

A. This has been offered to all eligible members through many do not wish to have it, as it increases their cost. Blue Shield is a voluntary organization and members have the right to select various levels of protection.

Q. I have patients who are covered under the Federal Employee Program. They say that they have to present itemized statements for service rendered. Is this necessary, and if so, why?

A. Services covered under the basic portion of the program are paid directly to the physician upon receipt of the regular Blue Shield service report. Itemized statements are required only for the supplemental portion of the program. By the contract negotiated between Blue Shield and the Civil Service Commission, itemized bills and receipts must be furnished by the patient to support payment of the additional benefits. This is necessary in order for Blue Shield to pay for only those services covered under this supplemental portion of the program. This also assures Blue Shield that a charge has been made for each service for which the patient claims benefits.

Q. Will Blue Shield make an allowance when an incision from a previous surgery has to be reopened and catheter inserted because of complications, bursting out original sutures, etc.?

A. This would depend on benefits previously paid in the current contract year. If the maximum had not been reached, an additional allowance would be made. Each case of this type would receive individual consideration.

Q. Under what circumstances will Blue Shield pay for dental surgery or for dental x-ray given following an accident?

A. Blue Shield Certificates of Membership exclude benefits for dental surgery. This includes dental x-ray.

In Memoriam

MELVIN VERNON WICKER
Wayland
1885-1962

Melvin Vernon Wicker, M.D., 76, in general practice at Wayland, Ky., for 51 years, died March 29 at Wabasso, Fla., where he was spending the winter. Doctor Wicker was graduated from the Medical Department of the University of Louisville in 1911. He was a native of Lackey, Ky.

HERBERT ROBERTS NUSZ, M.D.
Elizabethtown
1876-1962

Herbert Roberts Nusz, M.D., 86, Elizabethtown, a general practitioner in Hardin County for more than 60 years, died at his home at Elizabethtown April 1 after a long illness. Doctor Nusz was graduated from the Kentucky School of Medicine at Louisville in 1898. During World War I he served as a captain in the Medical Corps.

T. DeWITT GOODMAN
Ashland
1887-1962

T. DeWitt Goodman, 74, Ashland, died April 17 at his home after a long illness. His specialty was obstetrics and gynecology. Doctor Goodman was graduated in 1912 from the Medical Department of the University of Louisville. He retired from active practice in 1961.

JAMES PRESTON BOGGS, M.D.
Hazard
1873-1962

James Preston Boggs, M.D., 89, pioneer Hazard, Ky., physician, died at his Knott County home April 18. Doctor Boggs was graduated from the Hospital College of Medicine, Louisville, in 1896. He had been retired 10 years.

HARRY GARFIELD NELSON, M.D.
Fort Thomas
1879-1962

Harry Garfield Nelson, M.D., Ft. Thomas, died March 7 at his office in the Provident Bank Bldg., Cincinnati. He was an eye, ear, nose and throat specialist. Doctor Nelson moved to Fort Thomas 45 years ago. He was graduated from the Medical College of Ohio, Cincinnati, in 1906.

JOHN MacMILLAN TOWNSEND, M.D.
1906-1962
Louisville

John MacMillan Townsend, M.D., 55, Louisville, a physician for 31 years, died April 10 at Kentucky Baptist Hospital. He retired several months ago as associate professor of urology at the University of Louisville Medical School and had recently suffered with a heart ailment.

Doctor Townsend was graduated from the University of Michigan School of Medicine in 1930. He was a fellow of the American College of Surgeons and a member of the American Board of Urology and the Southeastern Section of the American Urology Society. He served as a Navy officer in World War II.

Mental Health Seminar Set

"Mental Health in Industry" is the subject of a one-day seminar to be held at Freedom Hall, Louisville, May 23. It is co-sponsored by the Jefferson County Mental Health Association and the Kentucky Department of Mental Health and intended to offer representative of Kentucky's industries and unions information about mental health techniques. Speakers and discussion leaders include: (all from Louisville) Edward E. Landis, M.D.; William K. Keller, M.D.; Warren M. Cox, M.D., and Harold L. McPheeters, M.D., Kentucky commissioner of mental health; Leslie Van Nostrand, M.D., medical director at General Electric's major appliance division; Robert L. Whitehouse, painting contractor, and Raymond A. Kemper, professor of psychology, University of Louisville.

Industrial Medical Assn. Elects

Charles E. Allen, Jr., M.D., Louisville, became president of the Kentucky Industrial Medical Association at the annual meeting March 15. Frederick P. Shepherd, M.D., Louisville, was named president-elect; Walter L. O'Nan, M.D., Henderson, vice president; Leslie Van Nostrand, M.D., Louisville, secretary-treasurer, and William J. Colburn, M.D., Calvert City, director.

Doctor Diamond Dies

Henry D. Diamond, M.D., 44, New York City, authority on cancer of the lymph glands, died April 19. Doctor Diamond was a 1944 graduate of the University of Louisville School of Medicine. He had suffered from Hodgkin's disease for 17 years and had become a recognized expert while studying the disease.

Robert C. Crabtree Dies

Robert C. Crabtree, Sr., 59, Louisville, well known to many in the medical and allied professions, died April 23 at Paducah. Mr. Crabtree was a former supervisor of the U. S. Narcotics Bureau at Louisville. He retired in 1959. He had worked the past month for the Granger Drug Company at Paducah. Mr. Crabtree was a graduate of the University of Kentucky School of Pharmacy.

The 28th annual meeting of the American College of Chest Physicians will be held at the Morrison Hotel, Chicago, June 21-25.

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J. VERNON PACE, 333 Broadway, Paducah ..... Jan. 1, 1962-Dec. 31, 1963
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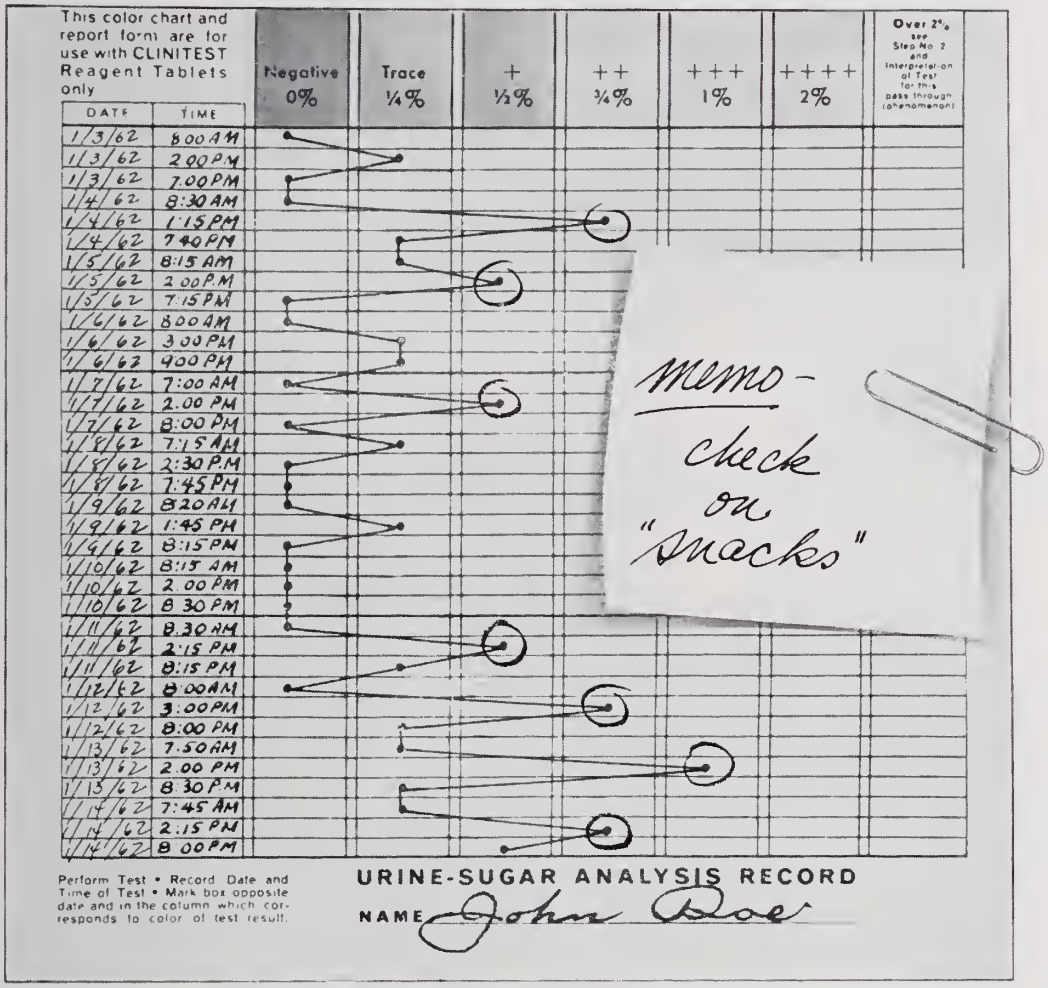
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*Schwartz, I. R.:
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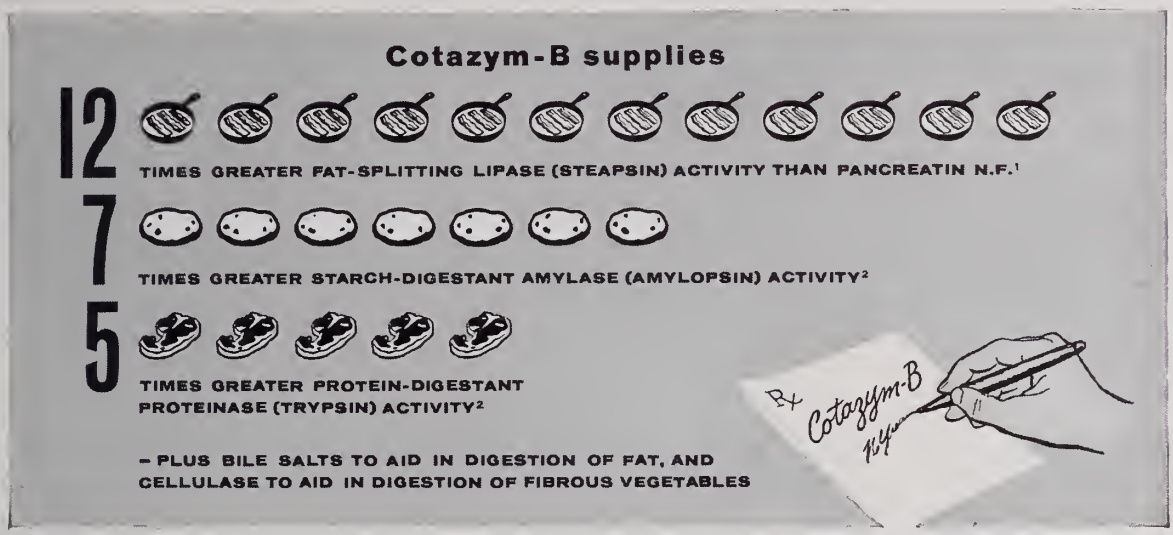
*Gamble, C. J.: Am. Pract. & Digest Treat. *11*:852 (Oct.) 1960. See also Berberian, D. A., and Slighter, R. G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Olson, H. J.; Wolf, L.; Behne, D.; Ungerleider, J., and Tyler, E. T.: California Med. *94*:292 (May) 1961; Kaufman, S.A.: Obst. & Gynec. *15*:401 (Mar.) 1960; Warner, M.P.: J.Am. M. Women's A. *14*:412 (May) 1959.

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MESSAGE FROM THE PRESIDENT

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SOCIAL SECURITY is a form of prepaid insurance and is not a payroll tax extracted from the working people of this country as are all other taxes.

If the pending King-Anderson legislation becomes a law, there will be no attempt, at a later date, to enlarge or expand the program to include more participants, at an ever greater cost to the Social Security program.

This mechanism cannot be considered a socialization of medicine, nor a vehicle which may be used for that purpose at a later date.

It is politically expedient for the present administrative branch of our national government to place 16 to 17 million Social Security participants under political obligation, by providing limited medical care to them.

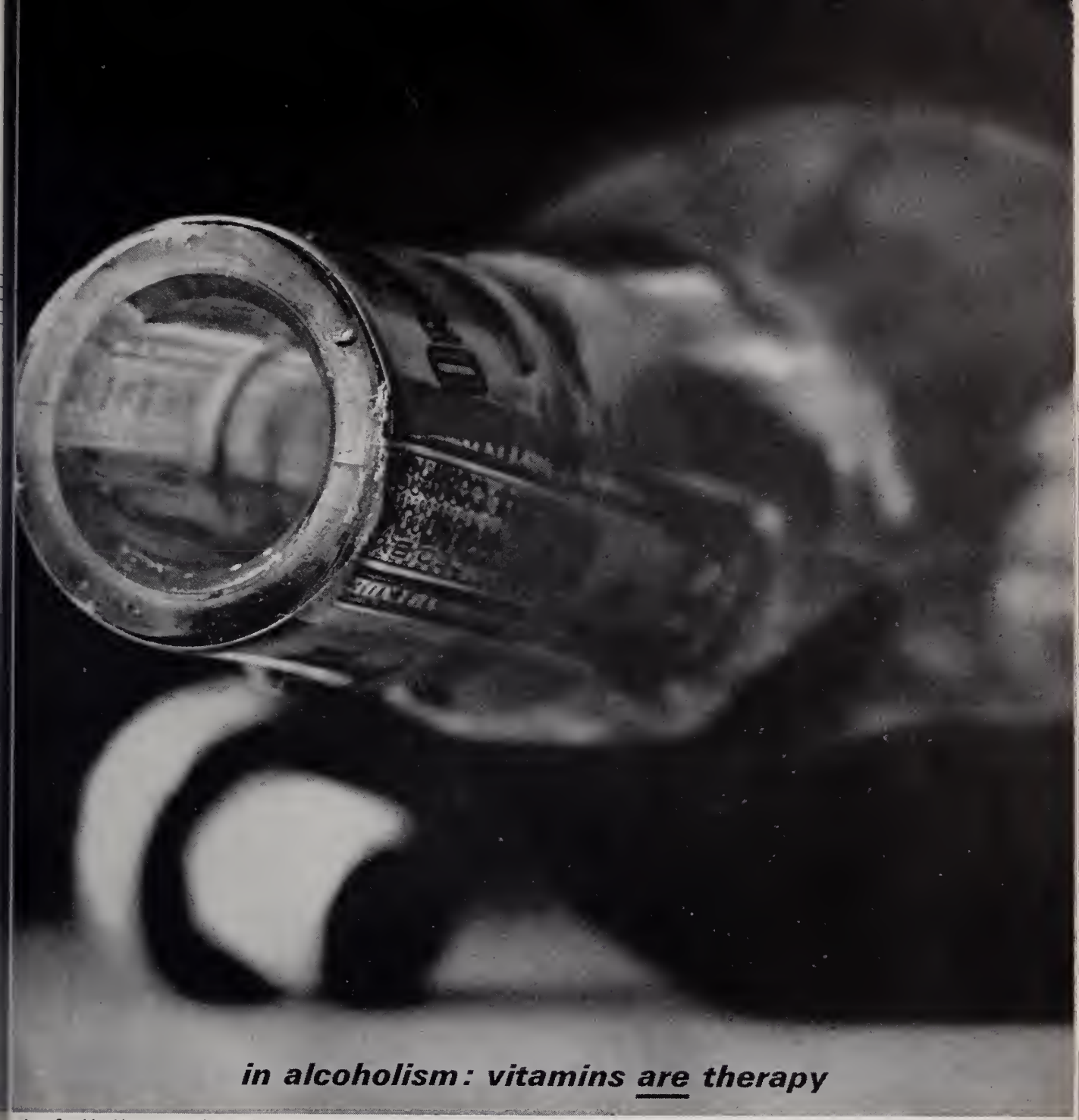
The AMA is autocratic with respect to freedom of its members, and it does not speak for the majority of them.

The elderly people of this country cannot be expected to intelligently procure their own medical care. It must be secured for them by governmental agencies.

Federal tax funds have not been used by the present national administration, executive branch, to attempt to sell the proposed King-Anderson legislation to the public.

The Little White House Conferences in 1961 were absolutely not politically motivated, and were not planned to promote the establishment of a medical care program for elderly Social Security participants in the Department of Health, Education, and Welfare.

D. S. Simpson



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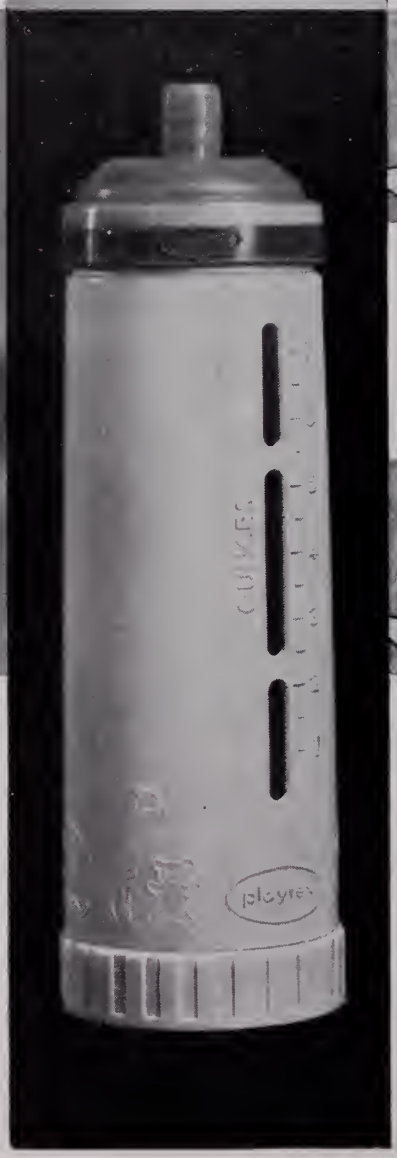
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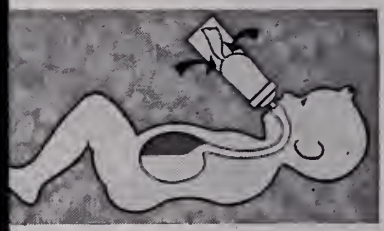


Because the disposable bottle is pre-sterilized, it eliminates the possibility of contamination through improperly sterilized bottles.





With conventional bottle air has to get inside bottle for milk to come out. Nipple often collapses and baby has to suck harder, so more air gets into his stomach. Both overfeeding and underfeeding can ensue, along with the aerophagia and flatulence which can produce colic, spitting up, and after feeding distress.



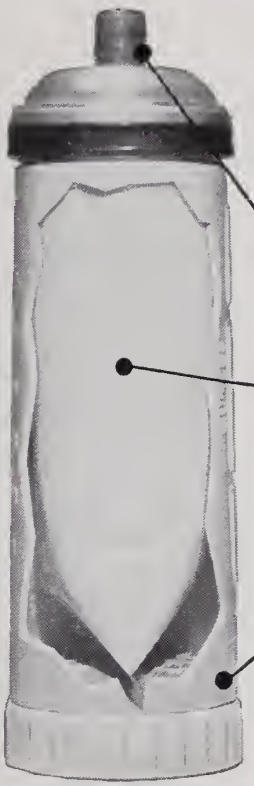
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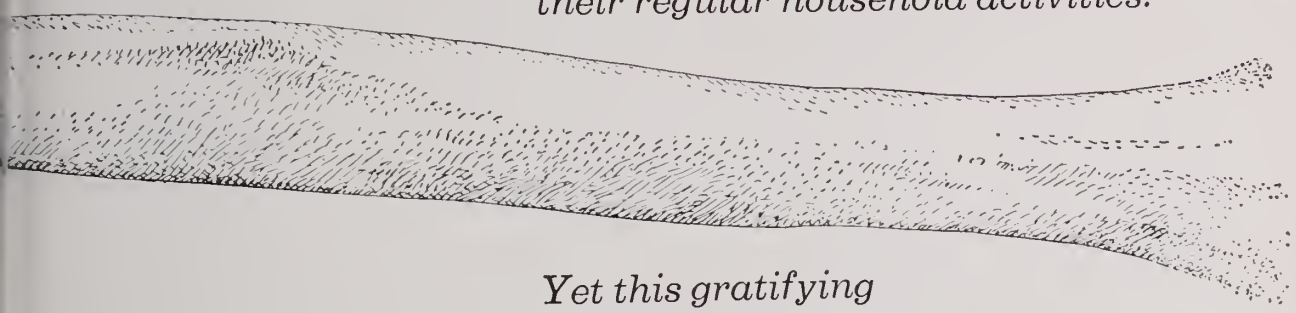
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WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—Top officials of the American Medical Association at a White House conference with President Kennedy stood pat in support of the Kerr-Mills program and in opposition to providing health care for the aged under Social Security.

President Kennedy also maintained his position that the Social Security mechanism should be used.

Using Boisfeuillet Jones, special assistant to the Secretary of Health, Education and Welfare, as an intermediary, Kennedy invited the AMA officials to the White House just before the Administration started an all-out effort to get Congressional approval of legislation that would provide limited hospitalization and some other health care to older persons under Social Security.

The House Ways and Means Committee, which rejected the Social Security approach in 1960, is expected to vote on similar legislation again this year.

In its campaign for the King-Anderson Bill, which utilizes the Social Security system, the Administration and its allies called rallies of aged persons, exerted pressures through a White House "lobby" office, published a propaganda pamphlet at taxpayers' expense and had federal employees drumming up support for the proposal.

Following the 45-minute White House session with Kennedy, Leonard W. Larson, M.D., Bismarck, N. D., AMA president, said the AMA representatives made clear that the great majority of the nation's physicians oppose the King-Anderson Bill or similar legislation. Doctor Larson also said the Administration is wrong in its statements that such legislation will be approved by Congress.

"We have a very good line of communication with the grass roots and the support of the old people for the Administration plan is decreasing now that they realize what it will mean to them," Doctor Larson said.

Doctor Larson charged that the Kennedy Administration is "trying to create a bandwagon" for its medical care for the aged program. He said "the propaganda indicates the Administration is not getting the support it needs for its bill, and we are convinced the trend is the other way."

In addition to Doctor Larson, AMA officials at the White House were: Hugh H. Hussey, Jr., M.D., Washington, D. C., chairman, AMA Board of Trustees; Percy E. Hopkins, M.D., Chicago, vice-chairman, AMA Board of Trustees; Norman Welch, M.D., Boston, speaker, AMA House of Delegates; Edward R. Annis, M.D., Miami, Fla., chairman, AMA National Speakers Bureau; F. J. L. Blasingame, M.D., Chicago, AMA executive vice president; Ernest B. Howard, M.D., Chicago, AMA assistant executive vice president.

Doctor Annis said the meeting "was an honest interchange of divergent views on the method of providing medical care for the senior citizens of our country." He said the AMA position was that when the government provided for people in need, this was "a proper manifestation of the Christian-Judiac consideration for fellow man."

But when the government provides for everyone under a system of forced contributions this amounts to socialized medicine, Doctor Annis said.

On other health matters, Kennedy expressed interest in the AMA-sponsored First National Congress on Mental Health this fall. He said he hoped to be able to accept an AMA invitation to address it. He also noted several legislative and other items on which there was substantial agreement between the AMA and the Administration, including aid for construction of medical schools and establishment of the health resources advisory committee.

Shortly after the White House meeting, Republican senators met and agreed to hold firm in support of the Kerr-Mills Bill and against King-Anderson. They refused to endorse any substitute.

One of the prime tactics of the Administration has been to give the impression that the King-Anderson Bill enjoys wide public support. However, Congressional polls of more than 450,000 voters revealed just the opposite with increasing public opposition evident toward the disputed plan. Of 43 polls taken during the current Congress, 28 showed strong popular sentiment against the bill. The latest 16 polls ran 12 to 4 against it.

The American Dental Association reiterated opposition to the King-Anderson Bill. An editorial in the ADA Journal stated, "participation in a government-sponsored program of health care should be voluntary." ADA Secretary Doctor Harold Hillenbrand called the bill "election time propaganda."

The campaign against the medical profession for its opposition to the King-Anderson Bill has become "downright vicious," Representative Don Short (R., N.D.) said.

"The distortions, untruths and half-truths that are making their rounds and being promulgated by various organizations in this country are astounding," he said in a Congressional Record statement. "Our fine physicians and dentists in this country are being portrayed as evil, money-grabbing monsters. Our medical associations are being portrayed in the same way. Nothing is ever said about the many sacrifices and the dedicated work of many physicians, dentists and surgeons . . ."

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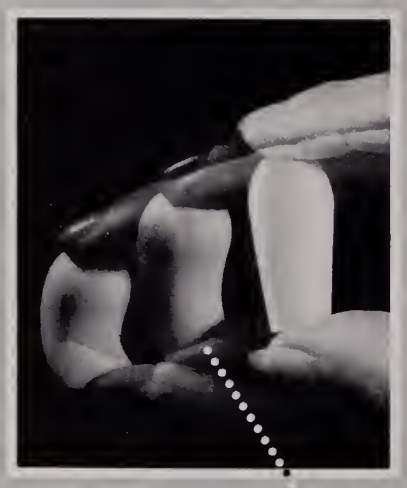
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The Private Practitioner in the Tuberculosis Program*

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The private practitioner will continue to play a major role in the campaign to eliminate tuberculosis in Kentucky. To be most effective, however, the physician must be abreast of the changing concepts of tuberculosis epidemiology and modern diagnostic and therapeutic procedures.

Introduction

UNTIL recently tuberculosis case finding, the treatment of the tuberculous patient, and subsequent rehabilitation were activities conducted and operated by almost exclusively the state and local health departments and state tuberculosis hospitals. However, with the advent of potent chemotherapeutic agents and highly successful thoracic surgery, the management of tuberculosis problems has shifted more and more from a largely institutionally oriented program to the office of the private practitioner. This growing change in the medical care of tuberculosis patients from a sanitorium and public health team to the private practitioner was brought about by the technical revolution in the treatment of tuberculosis during the decade of the 1950's.

Many physicians in practice today were trained in medical schools and postgraduate training programs when problems of tuberculosis were customarily referred to a sanitorium-type institution or TB specialty clinic. As a result, these physicians have had very little practical experience in treating patients with active tuberculosis. Yet, an increasing number of these patients are obtaining their treatment from their family physicians on an out-patient basis.

With the private practitioner alerted to recent improvements in tuberculosis case detection, diagnosis, treatment and rehabilitation, he should be able to manage the individual tuberculosis patient more effectively, yet recognize the limits of his knowledge and experience. It is the purpose of this paper to review a few of the changing concepts of tuberculosis epidemiology, and diagnostic and treatment approaches which the private practitioner must understand if he is to give his patients the most effective medical care for tuberculosis.

The Changing Epidemiology Of Tuberculous Disease In Kentucky

Most physicians recognize tuberculosis in Kentucky as one of the major public health problems of the state. The present tuberculosis death rate[1] in Kentucky is 13.0 per 100,000 population as compared with the national average of 6.6. The tuberculosis case rate is 50.0 in Kentucky and 36.4 in the U. S. as a whole. While over 4,000 cases of active tuberculosis were identified as of February 1960, it is esti-

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mated that there are an additional 4,000 "unknown" active cases in the State.

It is also of some interest that in Kentucky roughly one-quarter of the population 45 years old and over accounts for one-half of the newly reported cases and the relatively small portion of the population (10%) over 65 accounts for 20% of new active cases. However, less tuberculosis is being found in the pediatric age group. This general pattern of tuberculosis prevalence is not unique to Kentucky but typifies the pattern of the disease prevalence on a nationwide scale.

While it is obvious that the physician in practice must look for tuberculosis in any age group, he should be especially alert to the prevalence of this disease in the older age bracket. Moreover, 4,000 possible active tuberculosis cases are roaming at large and have escaped the usual public health case detection programs. These cases represent a challenge not only to the public health program, but to each individual physician who can play an important role in identifying these patients.

Tuberculosis in the future is most likely to be seen following a breakdown of apparently inactive disease, either in patients who once had clinical tuberculosis and recovered or those cases in which small lesions of questionable clinical significance have been followed merely with periodic examinations. It is recognized that patients who recover from tuberculosis without the benefit of isoniazid medication are more likely to experience relapse.

Diagnostic Techniques

Are there any new diagnostic methods or techniques to assist the private practitioner? The routine methods of chest film, tuberculin testing, and sputum or gastric smear and culture have not been supplanted by any "short-cut" laboratory tests. The question is frequently raised whether or not the "spot" sputum specimen would be worthwhile obtaining for bacteriologic smear and culture if a single 24-hour collection specimen could not be obtained. Especially with the patients seen in an office practice, there is sometimes difficulty obtaining 24-hour sputum collections. In a recent study[2] a comparison was made between the immediate "spot" sputum collection and an overnight specimen from 348 patients who had bacteriologically active tuberculosis. On direct examination 66.1% of the spot tests were positive on smear and 90.5% yielded positive cultures. It should be emphasized that in all cases these patients were known to have positive sputum. If two "spot" specimens were taken, the direct smear examination yielded a 76.4% positive result. This simply emphasizes that when the ideal diagnostic methods cannot be initiated one should not fail to at least attempt a diagnostic study with the immediately available sputum specimen. Too often patients are sent home with three sputum cups for 24 hour collections and, unfortunately, these people may never return, thus losing the opportunity for laboratory diagnosis.

There is also increasing interest in the use of sputum surveys for the detection of pulmonary tuberculosis because mass x-ray screening has yielded a decreasing number of new cases of tuberculosis in many communities. However, x-ray examination as a case finding procedure is still a basic approach which can be particularly productive in selected groups. High yields are still found in general hospital populations, alcoholics, migrant workers, lower socio-economic groups in slum areas, and correctional institutions. In a recent study[3] in a mining community in Wales, a sputum survey was undertaken in which sputum specimens were collected from approximately 2,000 adults. In this study no atypical acid-fast were found, but four definite positive tuberculosis cases were diagnosed bacteriologically and their chest films showed shadows compatible with the diagnosis of tuberculosis. It was of interest to note that all had uncavitated, streaky, or nodular lesions which were not extensive and in all cases a positive culture result was confirmed. None of these patients had sought medical advice and all were mingling daily with the rest of the community. It can be anticipated that the sputum survey may be of value in selected groups when high tuberculosis incidence communities have not or cannot be readily surveyed by a mobile x-ray unit. It may be possible to make a community x-ray survey more comprehensive by attempting to sputum test the high risk groups who do not participate in x-ray examinations. The "spot" sputum survey method might be worth investigating in some of our isolated mountain hollow communities in East Kentucky. The development[4] of the fluorescent staining technique for tubercle bacilli has made the sputum examination a more rapid and

practical public health laboratory test or procedure. With the availability of this new technique, we may anticipate further development and improvement of the sputum survey as a case-finding technique.

Atypicality and Sensitivity

When bacteriologic cultures are positive for Mycobacterium tuberculosis, drug sensitivity tests and, when indicated, tests for atypical organisms should be made. It is of some interest that in Kentucky very few atypical acid-fast organisms have been isolated from patients in the tuberculosis hospitals and clinics. Whether this is an accurate picture or simply a reflection of inadequate sampling or is an oversight in laboratory detection cannot be said with certainty at this time.

Pre-treatment drug susceptibility studies should be started on the routine diagnostic sputum exam rather than waiting for the hospital or clinic specimens. Drug resistant tubercle bacilli are becoming an increasing problem and account for the poor response to chemotherapy in many patients.

In a recent article,[5] James W. Raleigh, M.D., medical director of the American Thoracic Society, has pointed out the problem of increasing resistance of tubercle bacilli to the principal antituberculosis drugs—INH, streptomycin and PAS. In the U. S. as a whole, 8% of the previously untreated patients (so-called primary cases) excreting tubercle bacilli in their sputum have drug-resistant organisms to one of the principal drugs. He pointed out that of the 75,000 new cases of active disease reported annually in the U. S. we can expect that 6,000 will yield bacilli resistant to one of the three major drugs—roughly 2,500 resistant to INH, 2,500 to streptomycin, and the remainder to PAS.

The tuberculin test has been increasing in importance as a diagnostic tool in case finding programs of tuberculosis in community as well as office practice. There is increasing evidence[6] available indicating that tuberculin reactors with 10 mm. or more of induration to the intermediate strength PPD* have two to ten times the chance of revealing active disease at the time of the test or in the near future as well as strengthening the productivity in case finding through family contacts. The use of this testing procedure, of course, can result in the reduction in x-ray exposure to a population group and in the reduction of cost in case finding.

Whiie the Mantoux test is the most reliable procedure for tuberculin skin testing, it has the disadvantage of requiring adequate sterilization facilities and requiring skilled health personnel, such as the public health nurse or physician. Moreover, there is a definite time period for reading the skin test within 72 hours of application. It is also recognized that there are those who refuse or are reluctant to accept a needle puncture required for this test.

Several years ago a new instrument was devised by Professor Heaf of Wales. This device employed a spring activated lancet causing six needles to be driven into a predetermined depth through a drop of tuberculin on the skin. The Heaf test can be performed quickly with as many as 100 or more tests being applied per hour by personnel with only a brief period of training. Those receiving the test experience no pain and few severe local reactions. In a study[7] of a New York high school in 1958, the Heaf Multi-Puncture Tuberculin Test was applied to 61,000 pupils. The investigators found the Heaf test to be a satisfactory substitute for the Mantoux test in mass tuberculin screening programs. In the past year or two, many technical improvements have made the Heaf procedure safer, more reliable, easier to employ and more economical.

The Changing Approach to the Treatment of Tuberculosis

We are all aware of the effectiveness of the modern chemotherapy programs and surgical procedures resulting in more rapid and complete "cures" of tuberculosis. It can now be said with confidence that the previously untreated case of early tuberculosis can anticipate full recovery. In most instances, the infectiousness of tuberculosis patients can be reversed within a two to six month period. Moreover, many patients can now be treated with a minimum of bed-rest and, while initial hospital treatment is definitely recommended, under special circumstances effective home treatment can be provided without compromising the patient's chances of recovery. This startling change in the treatment of tuberculosis has met a mixed reaction among physicians in the U. S. However, solid scientific studies bear out the efficacy of home treatment provided that it is well supervised and judiciously administered.

* *Intermediate PPD = .0001 mg.*

An extremely well conducted study[8] by the investigators of the Tuberculosis Chemotherapy Center in Madras, India, has shown that the treatment of pulmonary tuberculosis with isoniazid plus para-amino salicylic acid at home was, in their patients, as satisfactory as treatment with the same combination of drugs in a sanitorium. Moreover, it did not appear to expose the patient's contacts to any special risks. In their most recent study 91% of 86 patients showed improvement with reversal of infectiousness. It should be mentioned that the patients in the Madras study are a group of poor villagers who had little rest, a poor diet, practically no nursing, and were actually not personally supervised in taking their medicines. Moreover, these workers[8a] concluded that examination of tuberculosis contacts, at the time of diagnosis of the index case, was a valuable method of case finding. In their study, the major risk to contacts during the year resulted from exposure to the index case *before* diagnosis. The contacts of patients treated at home were not exposed to special risk of infection when compared to contacts of sanitorium cases. Since these new cases arose particularly in contacts under the age of 7 years, it was suggested that young contacts of newly diagnosed sputum positive patients living in poor urban conditions of India, whether the contacts are tuberculin positive or tuberculin negative, might be protected by immediate course of chemoprophylaxis for a minimum period of six months.

Such results are not restricted to India. A recent issue of *Medical News*[9] reported a study of 1,377 ambulatory pulmonary tuberculosis patients treated by the Boston Health Department resulted in improvement and stabilization on x-ray in 88% even under the most adverse environmental conditions. Doctor Cohen, the chief examining physician of the TB program, pointed out that 80% of the patients were on welfare and 41% were alcoholics. The basic pattern of the program was that all patients who left the hospital, regardless of the reason for their discharge, were treated with chemotherapy. Isoniazid and PAS were used in combination in most instances, although isoniazid alone or isoniazid-PAS-streptomycin were used in some cases.

A major problem in home care of tuberculosis concerns the matter of patient cooperation in drug self-administration. Several methods for determining the degree of regularity in drug taking have been developed which can be accomplished by the private practitioner who elects to treat his patient on an ambulatory or domiciliary basis.

If the patient is on PAS medication a simple filter paper strip (Phenistix) test[10] can determine the presence of breakdown products of PAS. Isoniazid can now be determined by a chemical method[10a] modified for field use so that a few drops of urine and the appropriate chemical reagents can quickly indicate by a color change the presence of isonicotinic acid, one of the products excreted in urine after ingestion of isoniazid. A riboflavin-tagged isoniazid combination[10b] has also been successfully used to determine self-medication regularity by obtaining riboflavin levels in urine of patients on this drug combination.

Chemoprophylaxis

Most recent estimates indicate that 36,000,000 persons in this country are infected with the tubercle bacilli and that a large share of the new cases of TB are coming each year from this group. It is estimated that about 1 in every 1,000 infected individuals develops active tuberculosis each year. If a small daily dose of isoniazid for one year could eliminate that risk for any sizable proportion of the 36,000,000, we would have an effective method for preventing new cases and eliminating the sources of infection which threaten the uninfected.

At the present time the Public Health Service is evaluating 60,000 persons who are in particular risk of developing tuberculosis. About 33,000 of these persons are household contacts of tuberculosis cases and the rest are inmates of mental institutions in which tuberculosis is a problem. All these individuals get pills for one year, half of them placebo and half isoniazid. All candidates for the trial are tuberculin tested and x-rayed before admission. Any who are discovered to have active tuberculosis are treated and excluded from the trials. Participants are tuberculin tested and x-rayed again at the end of the pill-taking year. These patients will be followed for a number of years to observe how many develop tuberculosis during and after the prophylactic year. Thus, the place of chemoprophylaxis of tuberculosis has not yet been established, but preliminary results from the Public Health Service study have been promising.

Organization Against Tuberculosis

In May 1961, the Campbell House Conference[11] was held in Lexington, Ky. Twenty-four conferees and eight consultants met for a three-day period and designed a tuberculosis program tailored to meet Kentucky's needs. In addition to making specific recommendations, the Conference established itself as a permanent institution and as an integral part of the Kentucky Tuberculosis Association program, charged with the specific responsibility to maintain a constant study of the state tuberculosis problem. Only upon the attainment of the ultimate goal is this Conference to be dissolved and terminated. This report from the Campbell House Conference entitled "Recommendations for Eradication" contains important information for all physicians concerned with the tuberculosis problem in Kentucky.

In concluding, it should be emphasized that the physician in practice is not alone in combating tuberculosis. His allies include the expert chest physicians, the public health officers and public health nurses, the behavioral scientists, the health educators, vocational guidance people and rehabilitation workers. Excellent hospital facilities are strategically located in six of the so-called TB control areas of Kentucky and additional TB clinics are also available.

The Kentucky Tuberculosis Association with their local representatives in most communities are enthusiastic and experienced colleagues. It is essential that practitioners employ the most modern and up-to-date methods for the eradication of tuberculosis. The changing epidemiology of tuberculosis, the changing diagnostic approaches, and the changing treatment program—these have been reviewed in order to point up where the growing edge of tuberculosis knowledge stands at the present time. It is urgent that each practicing physician keep himself completely abreast of these rapid changes in tuberculosis management. If the physician in practice joins forces with the official and non-official agencies and health personnel in his community, the prospect of elimination of the tuberculosis problem in Kentucky can be achieved.

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Foibles in the Management of Bleeding Ulcers*

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Professional moral weaknesses contribute to mortality from peptic ulcer hemorrhage by delay in surgical arrest of the bleeding, failure to understand the physiology and management of the shock, sloppy diagnosis, and statistical turpitude.

THE problems in the management of bleeding ulcers are acute, dramatic, serious and not infrequently controversial. This is a compilation of the painful memories culled from approximately 200 severe cases, defined as will be shown, plus hundreds reported in the literature, defined differently or not at all.

The word "foible" is defined as moral weakness, failing or weak point.[1] The words "mistake," "error," "deception," "delusion," and "false dogma" are too strong. A physician who has one of these cases is in trouble, and like people, does his best when handled kindly.[2]

We do not intend to commit these foibles; sometimes we can't help ourselves. I have been protected from making all of them myself perhaps by not being in the required position of authority at the time. But there may be guilt by association, and as we are all in this profession together, we can all profit by the intercommunication of our embarrassments and henceforth, if we remember them, better serve our patients. To avoid stepping on specific people's toes, because there is apparently no gain to anyone in being personal, the foiblers will not be identified. Though some may feel they can detect a familiar scent behind the arras, it should be remembered: These slips have been made all over the world and will continue to be.

To the tissue morphologist the subject under discussion might seem to be the exsanguinating peptic ulcer. One school of gastroenterologists might feel it concerns patients with peptic ulcer who go into shock—again—within 24 hours of receiving a pint of blood. Another school will define them as peptic ulcer patients who faint when they stand. As we learn in blood donor centers, however, not infrequently a man will faint at the sight of blood which will not bother a woman. Another definition includes those patients who respond well to the slow transfusion of 250 cc. of blood per 24 hours. Yet another includes individuals who have had symptoms but not necessarily radiographic evidence of peptic ulcer, who have had any grossly visible amount of bleeding from either end. These were alleged to respond well to a diet of ground meat.

There is another group of doctors who take umbrage when pressed for a definition of what they are talking about, almost so as to imply, it would seem, that there is no significant relationship between the rapidity and persistence of the hemorrhage, the mortality rate and the management. To ask what they have in mind is to question their integrity.

Suffice it to say that, if they have a definition, no two unaffiliated groups seem to agree on what is talked about as bleeding peptic ulcer, nor on whatever adverb with which they may choose to modify the term "bleeding," such as "acutely," "grossly" or "massively." This glorious individuality and independence protects us from comparing any one group's therapeutic results with that of any other.

But such is our premium upon originality, that it would be a sorry candidate for academic promotion who would adopt any definition that was not original with himself or his chief. For example, the definition I employ was imposed upon me.

What then is the significance of these various types of definitions—none, vague, varying, subjective and variously objective, such as those

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based on physical, radiographic and laboratory findings? The point is that groups of patients fitting dissimilar definitions, though the methods of therapy be the same, will have different mortality rates.

This brings out that we are *not* talking primarily about patients with ulcers, but rather patients who are bleeding to death. When the resident phones to tell the attending surgeon about one of these patients, he says, "A bleeder just came in." He does not mean a hemophiliac. He does not say, "A patient with a peptic ulcer which has been bleeding has come in." This patient we are considering is known in our professional vernacular, and properly so, as a "bleeder." Why? Because that is the problem. It is the bleeding that kills. The ulcer is of comparatively incidental importance.

Severe Bleeding

This discussion concerns those patients who, under any method of management devised so far, have a mortality of 5 to 20%. They have severe bleeding, not just grossly visible bleeding. But there is no practical value in defining a patient so as to select his therapy after he is dead. We require a definition before treatment is to be started. Furthermore, one is needed even before there is evidence that the plan of management selected for the defined group is the best. Before one browbeats his colleagues into accepting a method of management, it would seem one should establish its supremacy. On an honest statistical basis this has not yet been done for massively bleeding peptic ulcer. Controversy has not been eliminated because nobody has yet presented an objectively defined, statistically significant, controlled series of cases of this condition. The alternate-case or the double-blind method would halve the potential size of one's series for the favored method of therapy. To make that approach statistical validity would take too long. The band wagon might long since have passed.

But in this particular disease, massive hemorrhage from ulcer, it appears that the band wagon will be with us for a long time, and there remains ample opportunity for young individuals of integrity and perseverance to find the truth in another 15 or 20 years.

This brings us back to the basic question whether the blood loss is related to the mortality rate. The point has been passed where it is necessary to add to the literature on that score. If a man loses only a teaspoonful of blood, it will not kill him. If he loses all of his blood and it is not replaced in time, he will die. Between these two extremes the mortality rates can be plotted on a graph. The most objective definitions of these patients, in terms of severity of disease, prognosis and necessity for radical therapy have been based on the rapidity and extent of exsanguination. While all definitions as yet employed have their shortcomings, that does not mean they are useless.

There is a time factor which, owing to the slowness of dilution of circulating blood following hemorrhage, may confuse the picture. Year after year physicians are heard to say, "I tested his hemoglobin and it is 15 grams, so I don't suppose he could have bled much." Yet there lies the patient, ashen pale, sweating, hypotensive, with a blood volume only 50% of normal. What is the answer?

When the hemorrhage started this morning, he was in apparent robust health, with a hemoglobin of 17 grams. It is a duodenal ulcer. Most of the blood is still in his intestinal tract, lost to his circulation. His circulating blood has not had time to dilute below 15 grams of hemoglobin. If the bleeding should perchance cease, and the patient be given liquids by mouth as desired, which would not be considered good management, it would take about 18 hours for the blood to dilute until osmotic balance would be achieved and the hemoglobin concentration drop to 7.5 grams.

Then there is the converse picture. A physician may be heard to say, "Hemoglobin 4 grams? Boy, that's really massive bleeding!"

It may be, and again it may not. If the patient walks in without help, he may have been oozing slowly from an ulcerated lesion for weeks. He has lost most of his red cells, but so slowly that he has been able to achieve considerable adjustment. His plasma volume, and if his heart begins to fail, even his blood volume may be greater than normal.

Questions arise as to where one shall draw the line. How much, in terms of objective measurement, must hemorrhage be to deserve the adjective "massive?"

Having noted first the acute and second the slow, chronic type of bleeder, the question arises whether the urgency for radical treatment is the same. Those who feel that with the slow bleeder there is not such a rush to operate are happy to accept an adverb to modify the adjective "massive," and will select "acute" or

"chronic," as the case may be, in search of precision.

Criteria

In 1946 my superiors felt, and of course I agreed, that by defining rigidly the cases to include in our series, we could avoid foibles which might vitiate the significance of the findings obtained. We established and, 15 years later, still follow these criteria which patients with massive, acute, upper gastrointestinal hemorrhage must satisfy:

1. Reasonable clinical evidence of peptic ulcer.
2. Bleeding within a week.
3. Red cell count 2,500,000 or less, or total circulating red cell volume less than 60% of normal.

These criteria are arbitrary, nothing magical. They are not to deny that a patient who apparently last bled eight days ago and has a red count of 2,600,000 had an acute, massive hemorrhage and may bleed to death tonight. These definitions were selected with the hope that we at least would know what we were talking about. There are reasons beyond those which have been given why they have not been generally accepted. One is that they are arbitrary. It would be nice to have them related to the mortality of medical management, as compared to surgical management. That would require evidence not yet available. Another obstacle is the reluctance of physicians to request and interpret blood volume determinations.

As time passed in 1946, and the thought of operating upon these people immediately made us anticipate criticism, other requirements were added, limiting patients' eligibility for surgery:

4. No evidence of blood dyscrasia.
5. At least 2,500 cc. of compatible blood available.
6. Adequate surgical and anesthetic personnel and facilities.
7. Criteria satisfied and patient operated upon within 24 hours of admission to the surgical service.

In retrospect, although these criteria were intended to avoid foibles, such is the ingenuity of human circumstance that the listed specifications fertilized new ones. This is not to deny that the set limitations were good. They were invaluable. But let us see what they did:

The foibles arising from the criterion requiring reasonable clinical evidence for diagnosis of peptic ulcer involved first the fact that at the time it was impossible to get an emergency upper gastrointestinal series out of regular hours. This was buttressed by the theory that a G.I. series in a patient with a massively bleeding ulcer would not affect the therapy. Illogically perhaps, at the time the feeling was current, which I now believe is not substantiated, that people with leiomyoma, lymphosarcoma, carcinoma and esophageal varices did not require emergency operation for hemorrhage. Later it was found that these did well with operation, and a surprising proportion of those with varices had bleeding from peptic ulcers.

Now that emergency G.I. series is accessible, in case of doubt it is employed. However, the wording of that first criterion stands because it is practical. It leaves room for the purely statistical but usually valid assumption that a man, asymptomatic in the past, with only the present acute, massive, upper gastrointestinal hemorrhage has a bleeding peptic ulcer until proven otherwise, and his chances are best if he is managed as such.

From the criterion requiring that the patient shall have bled within a week arise foibles of definition. What if the benzidine test is positive, the guaiac negative and the chief resident eager for another stomach on his list? Or conversely, if one is a believer in benzidine, what if it be the afternoon of the game? These are the hazards which beset the borderline case. Fortunately, because the definitions are not flawless, the borderline patient is not imperiled by the cloudy focus, though interpretation of the series can be blurred.

The same foibles pertain to the criteria that there must be a red cell count of 2,500,000 or less or total circulating red cell volume less than 60% of normal; only more so. The multitude of estimates, procedures and computations involved in achieving the figure of per cent normal circulating red cell volume, combined with the frank confession of a 10% margin of error in the determination, can make the specified 60% limit into a mighty fuzzy figure. There again, for the borderline patient one need not be so concerned about choice of treatment as for the validity of statistical conclusions.

The foibles that have arisen out of criteria four through seven are sufficiently similar to those from one through three that they need not be pursued.

Coexistent Disease

Theoretically, concurrent or intercurrent disease was not supposed to deny a patient the benefits of surgery—or spare him from the knife, depending on one's attitude. But then early in the series a bleeder had a stroke in the emergency room, a myocardial infarct on the operating table and died in propulsive failure shock 48 hours after gastric resection. So the theory fell, and the suspicion was, unwritten, that patients "moribund" from other causes than bleeding ulcer would go into the "control" series.

Now that early operative management has become a standard method, it may be fair to reaffirm the theory that a patient with massive hemorrhage from peptic ulcer plus an additional severe disease should have a better chance of survival if the bleeding is stopped and the blood replaced, even though to accomplish this may entail an extensive operation. This has not been fairly tested. The occasional case of painful memory does not constitute a valid, controlled series.

One who is gathering a series of cases has a severe problem of conscience when a patient who fulfills all the criteria for operation dies before surgery can be done. Technically can that be classed as a non-operative case and then slipped into the group of non-surgical controls? That question, of course, is rhetorical.

Diagnosis

Experience has shown that errors in the diagnosis of the cause of the bleeding have only minor significance in relation to mortality rate, in comparison with faulty understanding of the patient's physiology in hemorrhagic shock. As has been said above, these people are bleeding to death. Whether they have esophageal varices plus bleeding ulcer, a carcinoma, telangiectasia, leiomyoma, lymphosarcoma or a Meckel's diverticulum makes comparatively little difference. The patient is bleeding to death from an artery that is open inside the abdomen, and that vessel must be stopped. Once it is controlled and the lost blood replaced, there is plenty of time to attempt to remedy whatever the cause may turn out to be.

Errors in diagnosis of the cause seem to be lethal only where they delay recourse to surgical advice and therapy. If surgical consultation is called immediately in any case of gastrointestinal hemorrhage, the blood bank is less likely to be exhausted before definitive arrest of the bleeding can be accomplished. In relatively asymptomatic cases less experienced clinicians seem unwilling to play the averages and accept that nine times out of ten a massive upper gastrointestinal hemorrhage is from peptic ulcer.

Reference has been made to the lethal character of misunderstanding the physiology of hemorrhagic shock. Of particular importance is the foible demonstrated by underestimating the minimum tolerable blood pressure for a patient who customarily has been hypertensive. Prolonged throughout the blood replacement phase, this can be as lethal as no blood replacement at all.

Treatment

The initial big question, which involves so many factors, is whether the management should be medical or surgical.

There are prophets who attach greater severity at a given time to the prognosis of a patient who has had a greater number of episodes of massive hemorrhage. From an examination of the records of over 300 non-surgical cases, in the preliminary studies made before the commencement of Stewart's operative series in Buffalo, we interpreted that the prognosis in a given instance for a given episode of bleeding is the same, regardless of the number of previous episodes.

Then there is the foible of deciding for or against operation on the basis of the age of the patient, alleging that the older individual, with rigid vessels, has less of a chance of ceasing to bleed and also, because of impaired powers of healing, less of a chance of medically curing his ulcer. This is counteracted by the situation in the young individual, wherein, if he survives, his life expectancy for recurrences is greater than that of the old man, and besides, his youth favors a lower surgical mortality. Thus, as far as age is concerned, the various factors seem to cancel each other, so that in the last analysis age does not seem to make any particular difference in deciding whether or not operation should be performed.

Frequently among the numerous physicians considering the merits of proposed surgery in a given case, there is one who believes he can tell that bleeding has stopped, and that it is safe to wait until the patient's depleted stores have been reconstituted. Painful is the memory of

our first such case in 1947, examined on grand ward rounds, thought to be thus safe, and as the entourage was leaving the next room, a nurse came to report that the patient was dead.

What a surgeon hates to hear is, "The medical men have used up all the blood. Now they call us."

In an occasional instance there is a way out of this. Investigation may show that the patient is Rh negative, has never had a transfusion before, and there still is some Rh positive blood available, which can properly be used this once if definitive therapy will be accomplished at the same time. We have seen people chasing around looking for type AB donors, failing to realize that AB is universal recipient. Similarly, at times people even forget that type O is universal donor. A hazard of the universal donor is that occasionally, after type O blood has been transfused into a type B recipient, for example, some more donors with type B blood will come in, and this blood will be given to the former type B but now type O recipient. The significance of these errors is such that perhaps they should not be glossed over with the mild designation of "foibles."

More should be said about the so-called diagnostic test "trial of transfusion." If the patient does not pass the test, he is in worse shape than when it was started. The blood bank is some units poorer, perhaps depleted, and the blood that was given is poured out into the patient's gut or down the sewer where it can benefit nobody. This should be classified with those types of treatment where somebody is seeing if he can get away with something. In the surgical world, where nothing should be left to chance, this is inexcusable.

There are advocates of running the blood in slowly. They postulate danger of blowing out a clot that may have formed in a vessel, quietly covering their eyes to the thought of what may happen if there is no clot in that vessel. Then there are those who suggest that for a cardiac in shock one should run the blood in slowly. In such a case one should contemplate the blood supply to the coronary vessels. Unless the veins are congested, it is unlikely that the blood is going in too fast. A failing heart with an adequate blood supply can function better than a failing heart with an inadequate blood supply.

Then there is the patient, given a hypodermoclysis because it is alleged that he has no veins. Not only does he have veins, accessible to instrumentation and infusion, but arteries also. However, it should not be necessary to use arterics in anybody who has a patent common femoral vein.

Other Technical Problems

While we dare not but deny that it ever had any influence upon us, perhaps should be mentioned the insidious influence of nightfall, noted in retrospect by the statement, "We thought we would try to stick it out until morning."

There is the practice of delaying the operation until the blood pressure is normal, based upon a military theory. With all due respect to the uniformed, with whom I take issue on this point, it seems to make more sense simultaneously to stop the bleeding and replace the lost blood as soon as possible, regardless of the blood pressure.

There is the trick of blowing the blood in with a sphygmomanometer bulb when it doesn't seem to run fast enough. When things are not going too well at the operating table, this becomes a notorious source of intravenous air.

There appear to be foibles associated with technical details. Occasionally when a surgeon is in a hurry it is a temptation to the anesthesiologist to use an intratracheal tube without a balloon cuff. With manipulation of the stomach, then blood clots can pass outside of the endotracheal tube to plug the trachea.

Last year a consultant advised us that for these cases exploratory gastrotomy, pyloroplasty and vagotomy comprise just a quick little operation, and because of this are much to be preferred to gastric resection. Apart from other theoretical merits, so far, in three of our hospitals, this "little procedure" takes just as long.

Some surgeons insist that, if gastric resection is the operation of choice, the ulcer must be removed. Experience would indicate that the emphasis should be to stop the bleeding, regardless of what else is done then or later. In the case of a duodenal or benign high gastric lesion, removal of the ulcer seems unnecessary, as long as the source of bleeding is effectively controlled and the production of acid eliminated.

I have been told that if you can't close the duodenum, just stick a tube into it. I wish it were that simple.

Until 1956 we gave penicillin routinely to all our surgical gastrics. However, the pendulum began to swing again, so that now no one gets it prophylactically, and a comparison of our cases who have had it for this reason and who

have not had it indicates no statistically evident difference in the incidence of postoperative infections.

Summary

Foibles in the management of patients bleeding to death with peptic ulcer involve definition of case material, sources of statistical error, hemorrhage as the important part of the diagnosis, the necessity promptly to stop internal bleeding and replace lost blood, the merely incidental significance of the ulcer, the understanding of shock, and delayed or inadequate treatment. These reveal persisting opportunities for study and progress in the care of this lethal entity.

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Chronic Pulmonary Disease and the Heart*

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"With increasing incidence of pulmonary emphysema and other chronic pulmonary diseases, the relationship, manifestations and management of heart disease accompanying such conditions assumes much greater importance for all of us."

THE relationships between the heart and lungs, and their functions, are so intimate it is not surprising that disease or disturbed function of one often has a great effect upon the other. Diseases of both the cardiovascular and the respiratory systems are becoming more common. Therefore, chronic pulmonary diseases and their effects upon the heart assume increasing importance for all of us.

Serious effects upon the heart are found in individuals suffering from a wide variety of chronic pulmonary diseases. Among them are pulmonary tuberculosis, fungus infections of the lungs, pneumoconiosis (especially silicosis, asbestosis and berylliosis), bronchiectasis, chronic lung abscesses, tumors of the lungs, sarcoidosis, pulmonary infarctions (especially if these are numerous and repeated over a long period) bronchial asthma, cystic disease of the lungs, pulmonary fibrosis due to any cause, and chronic bronchitis. No matter which of these is present the accompanying pulmonary emphysema in most of them is the condition having the greatest influence upon the heart.

Because of the great (20 fold) reserve of the lungs the development of pulmonary emphysema and its effect upon the heart are usually insidious and slow in becoming recognizable. These manifestations appear in the period of life (40-70 years of age) when coronary heart disease, hypertensive heart disease or chronic valvular disease of the heart are also likely to be causing trouble so there is frequently a combination of harmful effects of disease of the one organ system upon the other. The pulmonary condition may be sub-clinical and overlooked until a superimposed acute respiratory tract infection precipitates symptoms. The role of such acute infections in upsetting the precarious balance or compensated state of these individuals cannot be overstressed.

Etiology of 51 Cases of Pure Chronic Cor Pulmonale—Hermann and Shields

Asthma—Bronchitis—Emphysema	33
Bronchiectasis	6
Congenital cyst of lung	3
Pulmonary fibrosis	2
Pneumoconiosis	2
Coeliac disease	2
Other conditions	3

Pathologic Physiology

In pulmonary emphysema there is loss of elasticity of the lungs associated with bronchiolar obstruction. There is a diminution of the maximum rate of expiratory air flow, causing a decreased maximum breathing capacity (reduced timed vital capacity). The residual volume of the lung is increased, the vital capacity is reduced, and the total lung capacity is normal or increased. Hypoxia and hypercapnia commonly develop in the later stages of the disease.

The decrease in oxygen saturation and increase in the carbon dioxide tension of the arterial blood are related to uneven alveolar ventilation and unequal perfusion of alveoli with blood. This situation will be aggravated whenever there is an infiltrative disease of the lungs along with the pulmonary emphysema interfering with exchange of gases across the alveolo-capillary membrane. Some alveoli are well ventilated, some are poorly ventilated. Some alveoli are inadequately supplied with blood. Cor pulmonale is invariably associated with pulmonary hypertension. Elevation of pulmonary arterial pressure is largely responsible

**Presented at the 1961 KSMA Annual Meeting.*

for the hypertrophy of the right ventricle and the development of right ventricular failure in pulmonary emphysema.

Pulmonary arterial hypertension is a result of an increase in resistance in the small arteries and arterioles. Structural alterations in the vascular bed as a result of chronic pulmonary disease undoubtedly contribute to the increased vascular resistance. There is a reduction of the pulmonary vascular bed. Hypoxia increases pulmonary arterial resistance and there is a close correlation between the increased pulmonary arterial pressure and the decrease in oxygen saturation of the arterial blood. The hypoxia also stimulates the production of erythrocytes leading to the development of secondary polycythemia. This causes increase in blood volume and increased viscosity of the blood which further aggravate the pulmonary arterial hypertension.

Recent studies indicate the cardiac output is decreased or normal in patients with emphysema and heart failure but in these individuals the cardiac output is higher than it is in patients with heart failure on the basis of systemic arterial hypertension or valvular disease.

Chronic Pulmonary Disease and the Heart

The primary disease in emphysema is pulmonary. The abnormal hemodynamics are due to structural changes in the lungs and hypoxia. On the other hand, the changes in the lungs in congestive heart failure secondary to hypertensive or valvular heart disease are related to alterations in the pulmonary circulation. In the latter there is a decrease in the compliance of the lung which is related to the increase in pulmonary vascular pressure, increase in pulmonary blood volume, and pulmonary edema. The vital capacity and total lung capacity are reduced. The residual volume is normal. The lungs are "stiffer." Therefore, ventilation is adequate though it may be reduced if there is much pulmonary edema. Carbon dioxide tension is normal or reduced slightly. Hypoxia may be present, but usually is not severe unless there is marked pulmonary edema.

These patients usually have a history of chronic cough and shortness of breath for many years. There is often an exacerbation of the symptoms secondary to an acute respiratory tract infection. There is often edema of the legs, cyanosis is present (and may be marked), the patient is short of breath at rest and usually prefers to sit up because this is the most comfortable position. In this position the neck veins are often distended. Because of the hyperresonance, cardiac enlargement usually cannot be detected. The liver is enlarged (it is often low without being enlarged when emphysema is present) and edema is present.

There may be signs of hydrothorax. There may be roentgenological signs of enlargement of the right chambers of the heart. One looks for a snub-nosed cardiac apex that appears to be lifted off the diaphragm and enlargement of the outflow tract of the right ventricle. In the lateral view the antero-posterior diameter of the heart may be increased. Right-sided cardiac enlargement is difficult to detect in many cases, but serial films may demonstrate significant alteration in the size and configuration of the heart.

The electrocardiogram may reveal evidence of right ventricular enlargement or strain.

Criteria For Diagnosis of Pure Cor Pulmonale

1. Evidence of hypertension of the pulmonary circuit:
   - A. Midsternal or epigastric heave.
   - B. Pulmonic diastolic shock.
   - C. Sharply accentuated and split P_2.
2. Definite evidence of right ventricular enlargement:
   - A. Electrocardiogram—right axis deviation, P_2 and P_3 tall and sharp.
   - B. Radiogram.
   - C. Right heart failure without left heart failure.
3. Absence of significant valvular lesions, systemic hypertension or ischemic heart disease with myocardial infarction.
4. Symptoms and signs of pulmonary disease.

Differential Diagnosis

It is important to differentiate pulmonary emphysema with heart failure from congestive heart failure of other etiology with associated pulmonary congestion and edema. Usually the patient with pulmonary emphysema will have a long history of cough and dyspnea and usually patients with emphysema and heart failure are deeply cyanotic. Older individuals may have increased anteroposterior diameter of the chest, limited excursions of chest walls and diaphragm, and obliteration of cardiac and hepatic dullness,

without having the physiologic abnormalities of pulmonary emphysema. The level of the diaphragm tends to be lower in patients with pulmonary emphysema than in those with pulmonary congestion and edema.

Enlargement of the heart usually cannot be detected on physical examination of patients with pulmonary emphysema. If a forceful apex impulse is felt to the left of the mid-clavicular line it almost excludes the diagnosis of cor pulmonale. Significant murmurs are seldom heard and auricular fibrillation is uncommon in cor pulmonale. The circulation time is usually shorter in patients with pulmonary emphysema and heart failure than it is in patients with heart failure secondary to hypertensive or valvular heart disease.

Vital capacity is reduced in both groups of patients but the residual volume is increased in pulmonary emphysema. Special equipment is needed to determine this. The maximum rate of expiratory air flow is markedly diminished in emphysema. In the patient with pulmonary congestion and edema this is not true unless the pulmonary edema is severe. In pulmonary emphysema with heart failure the arterial oxygen content is reduced considerably, the CO_2 tension is elevated, and the pH is decreased to a variable degree. In contrast, in pulmonary congestion and edema the CO_2 saturation is often less than in emphysema. The CO_2 content may be high following mercurial diuresis.

Unusual Conditions Simulating Chronic Cor Pulmonale—Hermann and Shields

1. Carcinoma of lung impinging on pulmonary artery..
2. Intracardiac aneurysm.
3. Thrombosis of pulmonary artery.
4. Essential pulmonary hypertension.
5. Constrictive pericarditis.
6. Tricuspid valvular disease.

The Electrocardiogram in Cor Pulmonale

Sinus tachycardia is common and is the predominant rhythm. Auricular fibrillation is uncommon (only 6% in one series of cases). There is typically, right axis deviation, electrically vertical position and clockwise rotation of the heart. Sharply peaked P waves in leads II, III and AVF are frequently found. Sometimes the R waves are unusually tall in leads V-1 and V-2 or in leads V3R and V4R. The ST segments become depressed in leads II and III and in the precordial leads. In these same leads the T waves may become diphasic or inverted.

There are definite limitations to the help one may obtain from the electrocardiogram. There is often a lack of correlation between the severity of cor pulmonale and the degree of abnormality of the electrocardiogram. The electrocardiographic abnormalities often occur only late in the course of the disease. They tell nothing about the functional capacity of the heart or of the cardiac reserve. Changes in position of the heart due to fibrosis, pneumothorax, pneumoperitoneum, pulmonary collapse or mediastinal shift may cause alterations in the electrocardiographic pattern that might be misinterpreted as being due to disease of the heart itself.

Treatment

The major effort should be directed toward improving pulmonary ventilation and restoring the oxygen saturation and carbon dioxide tension of the arterial blood toward normal. Right heart failure in patients with chronic pulmonary disease is most commonly precipitated by superimposed acute respiratory tract infection, such as bronchitis or pneumonia. Such infections should be treated promptly and adequately by anti-bacterial agents. This treatment, aided by the use of expectorants and bronchodilators, may relieve bronchial obstruction, improve ventilation, help correct the hypoxia, bring about a decrease in the pulmonary arterial pressure and a disappearance of the signs of right heart failure. Morphine, Demerol® and sedatives should be used with caution.

In these patients the respiratory center often has lost responsiveness to stimulation by carbon dioxide and breathing is regulated largely by the hypoxic stimulation of receptors in the carotid and aortic bodies. Therefore, oxygen therapy, although it would seem logical in these patients with so much dyspnea and such marked cyanosis, must be used with caution. Such therapy may eradicate the hypoxia and deprive the patient of his only stimulus to breathing. Stupor, coma and apnea may develop and lead to the death of the patient. This is likely to happen especially in the hypoxic, cyanotic and acidotic patient when oxygen therapy is used in high concentrations. If oxygen therapy is used in these patients they should be under close observation at all times and some mechanical aid to breathing, such as a tank respirator, should be used.

Suction of secretions from the tracheobronchial tree at times is helpful and necessary. Occasionally bronchoscopic aspiration will be a life-saving procedure. In some cases reduction of the respiratory dead space by performing a tracheotomy, will be very beneficial.

Treatment of the failing myocardium is less important, but often is helpful and necessary. The response to Digitoxin in these patients leaves much to be desired, but is frequently helpful and should be given a thorough trial. A low-salt diet and the use of mercurial diuretics may be useful in the edematous patients. Diamox® has been used but has proved to be of limited value.

A word should be said about prevention. Treatment of all acute respiratory tract infections promptly and adequately with antibiotics and bronchodilators may very well slow down the rate of development and lessen the severity of pulmonary emphysema that is in the process of developing in an individual. Some of the operations in use for treatment of pulmonary tuberculosis and other chronic pulmonary diseases (lobectomy, pneumonectomy and thoracoplasty) are sometimes followed by the development of chronic cor pulmonale. Treatment of these diseases in their early stages will obviate the need for such operations and reduce the likelihood of the development of chronic cor pulmonale.

Precautionary measures in industry to reduce harmful dust inhalation will also be beneficial in preventing pulmonary fibrosis and emphysema from developing. Keeping patients with bronchial asthma under good control may reduce the danger from future pulmonary emphysema and its complications.

Little has been said here about the occurrence of hypertensive, coronary, valvular and other types of heart disease in persons suffering from chronic pulmonary diseases. Long-standing back-pressure in the pulmonary venous system can and does lead to changes in the pulmonary arteries that may be followed by pulmonary arterial hypertension and chronic right ventricular strain. The reduced ventilatory capacity, the impaired alveolo-capillary membrane gas exchange, the reduced respiratory reserve, the tendency toward the development of hypoxia all tend to complicate matters whenever any other type of cardiovascular abnormality is present. These conditions make the management of such conditions more difficult for the physician and they make recovery from these conditions more difficult for the unfortunate patient.

Summary

The effects of chronic pulmonary disease upon the heart are becoming of increasing importance for all of us.

The importance of superimposed acute respiratory tract infections in upsetting the precarious state of compensation in these patients cannot be over-emphasized.

Elevation of pulmonary arterial pressure is responsible for the hypertrophy of the right ventricle and the development of right ventricular failure in pulmonary emphysema.

Hypoxia is an important factor in the development of increased pulmonary arterial pressure.

Treatment must be directed at control of the superimposed acute respiratory tract infection, correcting the hypoxia, overcoming the hypercapnia and supporting the failing myocardium.

The use of oxygen therapy in the hypoxic, cyanotic and acidotic patient is necessary, but is not without danger, and requires careful supervision.

Certain prophylactic measures may be helpful in reducing the incidence and seriousness of harmful effects on the heart secondary to chronic pulmonary diseases.

June is Dairy Month

A Systematic Approach To The Problems Of Infertility*

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Basic and associated factors in the barren marriage; newer technics in semen analysis and ovulation timing; a review of tubal, cervical and uterine pathology is presented. Alterations in hormonal physiology and genetic factors are discussed.

Medical literature on the subject of Infertility has become quite voluminous in recent years—truly a reflection of growing interest in a most challenging field. In spite of current gaps in our knowledge, which are rapidly being closed by advances in basic and clinical research, a systematic study of barren couples can be most rewarding. A review of one such approach will be presented.

Definitions

Sterility implies the absolute inability to reproduce. Generally, the absolute does not present a problem in reproduction. Therefore, in common usage it is synonymous with infertility.

Infertility refers to the relative inability to reproduce.

Primary Infertility refers to couples who have never been able to initiate pregnancy.

Secondary Infertility refers to couples who have previously initiated pregnancy, whether or not it was carried to a successful conclusion. The "one child sterility" problem falls into this group.

The approach to the study of the infertile couple may be divided into two parts. The first includes the basic requirements for fertilization to take place:

1. Normal spermatozoa.
2. Normal ova.
3. Patent passageway.
4. Adequate site for nidation of the fertilized ovum.

The second part includes associated conditions which are generally more difficult to evaluate. Their importance is well-recognized but their mode of action with regard to the solution of infertility problems remains somewhat indefinite. They will be discussed later.

The infertility study is always begun with a complete history and physical examination of both partners. At this time, infantilism of pelvic organs, poorly developed breasts, unusually long arms in relation to total body length and pubic and axillary hair development are noted.[9] External stigmata of endocrine deficiencies may provide the basis for laboratory investigation of some of the more difficult aspects in this field. Following this, the basic requirements for conception are investigated.

Semen Analysis

The semen should be collected in a clean, dry glass container and examined within two hours if possible. Since contact with rubber or powder leads to inaccurate interpretation, the condom specimen must be considered unsatisfactory. The masturbation specimen is preferred, although the interrupted coital specimen is usually adequate. Five tests are included in this determination:

1. *Appearance and volume.* The semen is usually opalescent and the quantity varies from 2 to 5 cubic ml. Excessive amounts of ejaculate

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are often poor in quality.

2. *Viscosity*. The ejaculate is usually "stringy" when picked up on the end of an applicator. Excessive viscosity may be associated with poor motility and the presence of pus cells from an acute or chronic prostatitis.

3. *Motility*. Evaluation is based on the percentage of motile cells, the type of motility and its duration. Motility is studied for 24 hours (at intervals) and grading is made on this basis. Absence of motility in an *adequately* procured specimen indicates sterility for that specimen. Hypomotility signifies relative infertility.

4. *Cell count*. The figure of 25,000,000 per cu. ml. is generally quoted as the low normal. Figures below this may well signify a degree of reduced fertility but only absence of motile spermatozoa should suggest absolute infertility for that specimen. Total counts in excess of 120,000,000 per ejaculate are considered acceptable also.

5. *Morphology*. Examination of the stained smear is a most important test for accurate semen evaluation. Abnormal forms, though always present, should number less than 20%.

Occasionally, a count of less than 25,000,000 is noted among fertile men. Sometimes conception occurs in the face of unusually high numbers of abnormal forms. Although these are exceptions, they tend to confuse the setting of definite standards.

Hotchkiss determined the effect on the semen specimen of frequent coitus.[7] He noted a reduction of volume and cell count, especially in these specimens assigned to the relatively infertile group. Following abstinence a reversal of this phenomenon seemed to take place. Morphology and motility remained unchanged. Based on these observations we advise specimens for analysis to be collected after at least 3 days of sexual rest.

For most men the basic cause for the "specimen of decreased fertility" remains unknown. It is always necessary to examine two or more specimens before any impression may be considered valid. Some of the causes usually listed are:

1. Congenital malformations, undescended testes, etc.
2. Infections, general or genital, especially mumps with orchitis.
3. Undue fatigue, excess worry, etc.
4. Endocrine imbalance; hypothyroidism.
5. Physiologic variations. (Excessive testicular heat, etc.)
6. Chronic illnesses.

The Ovum

Since recovery of the ovum is unusual, its presence is inferred on the basis of available procedures. Hence, there are *no true clinical methods* of determining its normalcy. Ovulations may be diagnosed by means of endometrial biopsy, hormonal assays (chemical and biologic), potentiometer recordings, daily vaginal smears and basal body temperature graphs. The procedures most commonly used among clinicians are:

1. *The Basal Body Temperature*. When the body temperature is recorded under "basal" conditions for an entire menstrual cycle, it tends to follow a definite "biphasic" pattern. Unfortunately, this determination is not completely specific. Some patients with typical biphasic curves have a proliferative endometrium in the immediate premenstrual phase of the cycle. Moreover, the exact time of ovulation with respect to the dip and rise in the temperature curve has not been determined accurately. In practice it is useful to assume that the point of rise of the temperature curve corresponds with actual ovulation and suggests the time of maximum fertility.

2. *The Endometrial Biopsy*. The luteal phase of the cycle is reflected in the endometrium by the presence of a secretory glandular pattern. This offers good presumptive evidence for the occurrence of ovulation. Hertig and others have been able to "date" the endometrium by using configuration of the glands and stroma as an index of luteal phase activity.[8] A fully mature secretory phase indicates a well-developed corpus luteum. Conversely, an immature or early phase indicates poor luteal activity. In the latter case, it is possible that fertilization without nidation may occur. On this basis, progesterone may be used logically as substitutional therapy for the "sick" corpus luteum.

3. *Daily Vaginal Smears*. When vaginal smears are taken daily and studied throughout a complete cycle, the change from the estrogen to the luteal phase may be noted. A drop in the cornification count and the disappearance of leucocytes during mid-cycle are significant. Occasionally the appearance of red cells may be noted.[9]

4. *The Fern Test*. Campos da Paz and others

have shown that cervical mucus in the presence of sodium chloride crystallizes when dry in the form of a palm leaf.[3, 5, 8, 20] This phenomenon is known therefore as "palming," "arborization" or more commonly "ferning." Estrogen seems to be necessary for this reaction. Following ovulation (or conception) the reaction becomes vague and the slide looks "dirty" or cellular.

5. *Test Tapes.* The presence of reducing sugars in the cervical mucus is responsible for the color changes in the various test-tapes in current use. Birnberg uses an impregnated cotton applicator which turns green at the time of ovulation.

6. Serial observations on the *viscosity* and amount of the cervical mucus are helpful in supplementing the other tests. The mucus becomes clear and "spins a thread" at the time of or just before ovulation when it becomes quite copious in amount. The pH, of course, should be alkaline.

When does ovulation occur? Earlier this was touched on briefly under Basal Body Temperature Curves. On the basis of operative records, ovulation is thought to occur from 14 to 16 days before the onset of the next menstruation (Ogino-Knaus). However, great variability has been noted. Hartman worked out the time of ovulation in monkeys, and frequently noted inconsistencies and irregularities. Cases of pregnancy following isolated coitus have been reported for every phase of the cycle including the menstrual. Farris has had some success in pin-pointing ovulation in the individual patient with his rat ovary hyperemia method.[4] Small amounts of the patient's urine are injected into two rats daily. The animals are then sacrificed and the color of their ovaries are compared with previously prepared standards. When the ovaries become as red as the standard, ovulation is said to occur.

What can be done for the patient who does not ovulate? It must first be stressed that not all cycles among normal women are ovulatory. Therefore, the diagnosis of anovulation may only be made after many cycles have been studied. Among the recommended hormones, the estrogens, the progesterones and the pituitary gonadotropins have all been listed as the drug of choice. More recently isolation of pure pituitary extracts have helped Buxton and Mastroianni to induce ovulation.[2] Greenblatt has reported a new substance, MRL/41, which seems to induce ovulation.[6] This substance was originally devised as another oral contraceptive. Although it inhibited ovulation in mice it failed to do this in humans, and, in fact, seemed to have just the opposite effect. In general the newer synthetics such as Norlutin or Enovid (containing the 17-nortestosterones) can be used cyclically to produce artificial periods, and after their withdrawal ovulation may occur spontaneously.

Another valuable treatment for anovulation, especially with amenorrhea, is low-dosage irradiation to the ovaries and pituitary as advocated by Kaplan.[9] The geneticists have been loud in their criticism of irradiation in the wake of the hysteria following the explosion of atomic devices and subsequent fall-out. This has effectually put the quietus on a method which has had a large degree of success in the hands of Mazer and Israel, Randall and Dougherty and many others.

It must be pointed out again that there are no practical means for determining the normalcy of the ovum. It is interesting to compare this fact with semen analysis. Some abnormal spermatozoa are present in all fertile specimens. Can abnormal ova be a factor in sterility? Does the abnormal ovum resist fertilization? May this be the cause of infertility among patients in whom no other factor may be found? These are interesting questions for speculation at this time and perhaps for future investigators to answer.

The Passageway

The canal to be traversed by the sperm extends from the vagina, through the cervix and body of the uterus to the Fallopian tube. Although normalcy enhances the possibility of pregnancy, patency is the minimal basic requirement. Obstruction may occur at any point and must be overcome before conception can be achieved. Only the more usual types of obstruction will be considered. Congenital malformations must always be kept in mind.

1. *The Vagina.*

a. Faulty coital technique, vaginal occlusions, organic barriers such as impenetrable hymen, or functional problems such as vaginismus may be potent obstructions to conception. Such a faulty start may place the sperm at a disadvantage it cannot overcome.

b. Inflammatory lesions with acid discharges may devitalize even virile sperm. The Huhner test, in which the vagina and cervix are examined postcoitally for living sperm, may demonstrate this chemical obstruction. This test is an integral part of the infertility study.

2. *The Cervix.*

a. Inflammatory lesions. Although cervicitis is rarely a barrier in the fertile couple, it seems to be important to the general problem of infertility. Among some patients, the discharges are definitely hostile to the advance of the spermatozoa. In any event, the lesion should be treated adequately, especially if it is grossly purulent.[14]

b. Stenosis or atresia. When the exit of menstrual discharges is not impaired, there is no logical explanation for stenosis causing infertility.[13] However, the number of pregnancies which follow cervical corrective manipulation are more than mere coincidence would seem to warrant. Dilatation and curettage, hysterosalpingography and tubal insufflation often seem to be therapeutic as well as diagnostic measures.[1]

Rabbits are known to ovulate at the time of coitus, hence their reputation for prolific breeding. The possibility of pituitary-gonadal stimulation following cervical stimulation definitely exists. This relationship cannot be demonstrated in man but possibly with improvement in our laboratory technics we can achieve proof of a phenomenon we all believe exists.

3. *The Tubes.*

a. Inflammatory lesions are the greatest single cause for sterility. In a series of patients presented by Siegler, 50% had trouble because of a tubal factor.[19] Following an attack of salpingitis, the tubes may return to normal, maintain foci of chronic infection or become occluded. There are two widely used methods for determining the status of the tubes.

1. *Rubin Test.* Carbon dioxide under controlled pressure is introduced into the uterus by means of a cannula fitting well into the cervix. The system may be connected to a drum in order to record results graphically. It must be remembered that spasm may lead to the false impression of tubal closure. Before the tubes are labelled non-patent, insufflation must be repeated with the aid of sedation and antispasmodics.[17] Shoulder pain or X-ray demonstration of gas under the diaphragm is positive evidence of patency.

2. *Hysterosalpingogram* offers graphic proof of the status of the tubes. Lipiodol or other iodized oil offers the advantage of permitting delayed study. Occasionally patency is found only on the 24-hour film. These films also point to the site of obstruction. Rapidly absorbable media are preferred by some but they do not permit delayed observations. Contrary to popular opinion, they, too, may produce foreign body granulomata.[12]

What can be offered to patients with tubal block? First, repeated insufflation with pressures to 250 mm. of mercury may overcome the obstruction. Second, conservative plastic tubal repair, in selected patients, has proven successful for conception in about 15% of the cases operated upon. Patency may be achieved in a larger number, but pregnancy does not necessarily follow. Physiotherapy, principally deep heat in the form of diathermy, has also been helpful occasionally. More recently, cortisone has been advocated for the more chronic and stubborn cases.

Nidation Site

Successful nidation of the fertilized ovum requires a relatively normal endometrium in the late secretory phase. The studies of Hertig, in which the development of the secretory reaction was measured, may be most important in this connection.[8] The fault may be a poorly developed corpus luteum or perhaps a hypoplastic uterus. In either event, administering progesterone to these patients may be worthy of trial.[11] If the use of estrogens in treating the truly hypoplastic uterus proves unsatisfactory, further study of the pituitary should be undertaken.

a. *Malposition of the Uterus and Infertility.*

On the basis of established facts, there seems to be no specific relationship between the malposed uterus and infertility. The association of retroversion with a high degree of fertility occurs too frequently to consider this a serious cause. Unless the uterus is fixed in malposition and is causing symptoms, it would appear best to direct therapy elsewhere. Fixation of the uterus may provoke infertility or repeated abortion, and is usually associated with endometriosis.

b. *The Relationship Between Uterine Fibroids and Sterility.*

This has received considerable attention. If one subscribes to the theory that excessive estrogen secretion is related to the development of fibroids, one may assume this same cause to be a factor in infertility. In any event, only after completion of the study, and in the absence of more active deterrents to pregnancy, should myomectomy be performed. If the fibroid has occluded the passageway, pregnancy may follow. It is difficult to evaluate the many reports of success following removal of fibroids

in other locations. To the reader they may seem to be coincidental; to the surgeon, they are always the direct result of the procedure.

Uterine anomalies. Uterus didelphys may be responsible for infertility. The operation of Strassman can restore such a uterus to normal in some cases.

Associated Factors

After the basic requirements have been established within the limits of our present knowledge, the associated factors must be investigated. Unfortunately, despite their importance, their specific relationship to infertility tends to remain vague.

1. *Endocrine Factors.*

a. *The thyroid gland.* The relationship between this gland and the pituitary-gonadal axis is well established, although its direct mode of association is still unknown. Where obvious malfunction is present, it must be corrected. However, most patients present minor and relatively asymptomatic variations from normal. The usual laboratory tests such as the BMR, PBI and radioactive iodine uptake may all be normal, and in spite of this many clinicians give thyroid empirically. One should keep the dose low so as not to suppress the natural secretions of the gland.

b. *The ovary.* The secretions of the ovary have been discussed earlier as they relate to the site of nidation. Cases of ovarian failure or agenesis should be investigated as possible Kleinfelter's Syndrome or pituitary failure. Removal of simple or functioning ovarian neoplasms may restore that gland to normal.

c. *Adrenal and pituitary glands.* In recent years interest has been directed toward better diagnosis and treatment of pituitary lesions with some success. A patient of ours with pituitary hyperplasia and Cushing's Disease was treated by rotating radiation to the pituitary and by bilateral adrenalectomy. While she was being maintained on adrenal corticoid replacement therapy she unexpectedly conceived!

Masculinizing lesions of the adrenal as a result of hyperplasia of the gland can be treated with cortisone. In fact, corticoids may be used as a test to differentiate between tumor of the adrenal or ovary and pure adrenal hyperplasia.

2. *Age of the couple.* Obviously as age advances, the general possibility for conception tends to diminish. There are no absolutes here, of course, but in the case of the infertile couple, advancing age tends to assume a greater degree of importance than in the normal fertile group.

3. *Diet and environment.* Tension and poor dietary habits seem to militate against pregnancy. Some couples conceive only when on vacation! We do not hesitate to recommend this form of relaxation as part of the therapeutic armamentarium. A high protein, high vitamin type of diet is recommended also and efforts to control obesity are actively encouraged.

4. *General health of the couple.* Frequent attacks of acute illnesses or untreated chronic diseases tend to decrease fertility potential.

5. *Psychic and emotional factors.* Our present tests are sadly inadequate to demonstrate these effects, although the part they play is well known. The tension-anxiety influence on conception is commonly observed.[16] Javert has installed a psychiatrist as a member of his team at the infertility clinic at Cornell.[10]

6. *Endometriosis.* Although normal cyclic activity may be observed, there is a high incidence of infertility among patients with endometriosis. Conservative surgery is often followed by pregnancy.

7. *Miscellaneous and unknown factors.*

a. Much work is now being done on intersex problems and females who may reveal male sex chromatin in their cells and vice-versa. "Super feminine" types are being found showing the xxy or xxx type of chromosomal pattern. These patients may be mentally retarded as well as infertile.[2]

b. Often minor deviations from established procedure may prevent conception. Recently a patient was seen who used Tampax after coitus in order to "help retain the semen within the vagina." Postcoital douching is not infrequently used "for cleanliness" and at least once in a lifetime one sees an infertile couple who have never achieved vaginal intercourse! Only time and patience can elicit the many facets of the "insoluble" problems in infertility.

Special Therapeutic Procedures

1. *Glucose-Ringer pre-coital douche.* This is mentioned only because it was once thought to be an important step in treatment. Aside from its theoretical advantages, no practical results have come from its use in the hands of most of those interested in this subject.

2. *Use of the contraceptive diaphragm to retain the semen* within the vagina is occasionally recommended. The diaphragm must be clean, free of any powder and dry. It is inserted immediately after intercourse and left overnight.

It may be of some value where the cervix is pointed away from the seminal pool, and it permits lying on the abdomen without loss of semen.

3. *Exercises.* These are directed toward improving the general well-being and are nonspecific.

4. *General Hygienic Measures.* When indicated, corrections should always be made.

5. *Coital habits* should be investigated and regulated if unreasonable. Too frequent coitus may be as bad as too infrequent coitus. The only occasional coitus may miss the fertile period for many months.

6. *Artificial insemination.* When used with the husband as a donor, this has been described as giving the sperm "a two-inch boost on a six-inch journey." In the absence of refractory cervical lesions, its value is generally doubtful, although in our hands conceptions have occurred with its judicious use.

When the husband is proved sterile, the use of a heterologous donor may be considered. If the female partner is normal, conception frequently takes place. Both partners must fully understand the procedure and the responsibility of the physician. Its legal status is still open to some argument and has not been decided fully. From three to six cycles may be required, with two inseminations during each cycle. Seventy-five per cent of a selected group of our patients achieved pregnancy with insemination.

Our present technic for therapeutic insemination of either type described above combines placing sperm in the exocervix and the endocervix using a plastic, polyethylene cervical cap. The semen specimen is drawn into a clean, sterile syringe and a small amount is injected into the cervical canal. The cap, into which a small hole has previously been drilled near its uppermost edge, is then fitted over the cervix. The remainder of the specimen is injected without difficulty into the cap. Very little semen will be lost as the principle is the same as drilling a hole in a milk bottle cap, filling the bottle with water, securing the cap and turning the bottle upside down. The atmospheric pressure holds the water in the bottle in spite of the small hole. The ease of administration renders this technic the easiest of described methods.

Summary

1. The principal and associated factors in the problems of infertility are discussed.

2. Several pathways for future investigation are touched upon.

3. The recommended forms of therapy are presented.

4. Emphasis is placed on the advantages of planned investigation in solving a couple's infertility problem. A better understanding of the problem often leads to its successful solution.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Acute Pancreatitis Associated with Cholelithiasis*

Richard C. McPherson, M.D.**

History and Physical Findings

V. R., No. 168-719. The patient was a 35-year-old negro female who was perfectly well until three days before admission, when she awakened with a feeling of upper abdominal distention. Bicarbonate of soda gave partial relief, but residual tenderness in her upper abdomen remained. This tenderness was aggravated by deep breathing, coughing and lying on her back. Anorexia followed and on the day before admission the patient became nauseated and vomited approximately 10 times. She also noted that her urine was darker than usual and that after several bowel movements her stool color changed to grey. The pain and tenderness remained in the upper abdomen and seemed to encircle the body at this level.

The patient had received no injections or medications within the previous two years nor had she been in contact with any known jaundiced person. No history of food intolerance or previous indigestion could be elicited.

The physical examination showed an obese woman, groaning and moving about restlessly in bed, complaining of upper abdominal pain. The temperature was 99.6° orally; pulse, 110; blood pressure, 150/90; and respirations, 30. Her height was 5'4", and her weight was 187 pounds. The skin was dry but of normal turgor. The sclerae were slightly yellow. Epigastric and left upper quadrant tenderness with rebound tenderness were present. Bowel sounds were hypoactive. Rectal and pelvic examinations were normal but confirmed the presence of grey stool.

The initial impression was acute cholecystitis with possible acute pancreatitis.

Comment

Initial history and physical examination point to an upper abdominal inflammatory process. Tenderness aggravated by lying down suggests involvement of retroperitoneal structures. The grey stools with the marked amount of pain and tenderness point to obstructive jaundice. Not many acute abdominal conditions give pain in the left upper quadrant, but one condition to be considered is pancreatitis. The patient clearly stated she felt the pain as encircling the upper abdomen. This is consistent with the band-like abdominal pain of pancreatitis. It must be remembered though that only if the entire pancreas is involved does the band-like or encircling pain exist. By implanting electrodes in the pancreas Zollinger and Boles[1] showed that stimulation of the head of the pancreas gives right upper quadrant pain; stimulation of the body, mid-epigastric pain; and stimulation of the tail, left upper quadrant pain. Only when all parts of the pancreas are stimulated simultaneously does the patient experience the band-like abdominal pain.

The pulse rate of 110 can represent dehydration, reaction to pain, impending shock or a combination of these. The rapid respiratory rate reflects shallow breathing from splinting of the diaphragm that patients with upper abdominal inflammation commonly exhibit.

Hospital Course

A flat plate and upright film of the abdomen and a film of the chest showed no abnormality other than a small amount of air in the small bowel, consistent with mild ileus.

Blood was drawn for CBC, electrolytes, BUN, alkaline phosphatase, cephalin flocculation, bilirubin and amylase. Through the same needle an intravenous infusion of normal saline was started. A nasogastric tube was inserted and placed on low suction. All intake and output were recorded.

Comment

X-rays of the abdomen and chest are helpful when considering pancreatitis or cholecystitis, principally in attempting to exclude other causes of abdominal pain. One looks for free air in the peritoneal cavity or evidence of mechanical obstruction of the small bowel. Lower lobe pneumonia may give signs and symptoms of upper abdominal disease. A small amount of pleural effusion on the left may be seen in pancreatitis, probably due to irritation just below the diaphragm.

Because of the profuse vomiting and clinical signs

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of dehydration, electrolyte determinations were desirable. The presence of jaundice indicated the alkaline phosphatase, cephalin flocculation and bilirubin examinations.

An amylase determination is the single most important laboratory test for detecting pancreatitis. This may be measured in the serum, peritoneal fluid or urine. Since an elevated serum amylase may return to normal in two or three days, a patient seen late in his illness may have a normal value. Peritoneal fluid amylase levels usually remain elevated for four or five days. Since free peritoneal fluid commonly is present with pancreatitis, an abdominal paracentesis with an 18 gauge spinal needle may result in obtaining 0.5 to 1 cc or more of fluid for analysis. The measure of urinary amylase is less reliable and therefore not commonly used.

Renal insufficiency may interfere with the normal excretion of amylase and thereby give a false high value. A BUN determination should help exclude this possibility. Mention should be made also that amylase values may be elevated in other abdominal disease such as perforated duodenal ulcer or mechanical small bowel obstruction.

Serum lipase remains elevated for a longer period than serum amylase and is a reliable test for pancreatitis. The disadvantage, though, lies in the fact that the procedure takes several hours to perform.

When dehydration is present, extracellular fluid is depleted. Replacement of both water and salt is required. Therefore, in dehydration, a normal saline solution is the first fluid started, whether or not the serum electrolyte concentrations are known at the time.

Because nausea and vomiting were prominent features in this patient's illness and cholecystitis and pancreatitis were suspected, a nasogastric tube was inserted. This would serve a twofold purpose, that is, prevent distention and lessen the acid-secretin sequence for pancreatic stimulation.

Hospital Course Continued

By two hours after admission several of the laboratory reports were returned. The CBC showed the hemoglobin to be 14.9 gm %; hematocrit, 45%; and the WBC, 11,600 with 86% polymorphs. The amylase value was 2490 Symoygi units. The urinalysis gave an acid reaction and a specific gravity of 1.030. The electrolyte determinations showed Na, 132 meq/1; K, 4:6 meq/1; Cl, 94 meq/1; and CO^2, 28 meq/1. Later in the day the total bilirubin was reported as 3 mgm %.

Atropine, 0.4 mgm., was begun intramuscularly every six hours; and meperidine (Demerol®) was ordered for pain. The patient was also started on aqueous procaine penicillin, 600,000 units, and streptomycin, 0.5 gm., twice daily.

Comment

The amylase value of 2490 was quite striking. Although the established limits of normal may range from 50-200, we usually consider a value over 300 as significant and over 1000 as diagnostic of pancreatitis. The degree of elevation, however, does not always correlate with the severity of pancreatitis.

The CBC and urinalysis were not remarkable other than reflecting the mild dehydration that was clinically apparent. The electrolyte values indicated mild depletion consistent with the patient's history and physical findings. The total bilirubin of 3 mgm % could be compatible with a common duct stone, but also is consistent with edema of the common bile duct or head of the pancreas causing bile stasis.

Atropine was given to block the vagal effect on gastric secretion and the vagal influence on the gallbladder and pancreas. Meperidine (Demerol®) is given for the pain of cholecystitis or pancreatitis. Morphine is contraindicated since it causes spasm of the Sphincter of Oddi and may make either condition worse.

The indications for antibiotics in this patient are probably debatable. While it is true that in most instances cholecystitis or pancreatitis begins as a chemical inflammation, bacterial infection may become superimposed. Certainly it is true that when the illness is prolonged and complications such as empyema of the gallbladder or pseudocyst of the pancreas result, bacteria are commonly cultured from these areas.

Treatment for acute pancreatitis is symptomatic and nonspecific, but the supportive measures taken are of proved merit. The acute process in the pancreas itself, in all but the most severe stages, is mostly reversible. If the patient can be tided over the acute phase of his illness, chances for survival are excellent. Enzyme inhibitors may become effective and perhaps specific treatment in the future. At present, though, restoration of blood volume deficit has probably been most responsible for decreasing the mortality of pancreatitis in the past 15 years. Determinations of blood volume deficits have shown an average loss of 1500 cc whenever pancreatitis is accompanied by significant ileus.[2] This deficit appears within the first few hours and accounts for the sudden appearance of shock in many of these patients. If shock does occur the resulting loss of blood supply to the pancreas can convert a mild pancreatitis to a frank hemorrhagic and necrotic pancreatitis.

Blood volume deficits are due to both edema and ascitic fluid, formed in and about the pancreas, and to the accompanying ileus. In the absence of prolonged ileus the blood volume deficits have been minimal. However, when the patient is first seen it is impossible to determine the severity of his pancreatitis and ileus. Therefore, measures to restore possible blood volume deficit should be started in the first few hours. Whole blood, plasma, or concentrated albumin best restore the circulating blood volume. In those patients with little or no evidence of ileus normal saline alone may be adequate.

Hospital Course Continued

By eight hours after beginning therapy there was a noticeable decrease in her abdominal tenderness and vital signs were improving. A second liter of normal saline was given the first 24 hours together with 1000 cc of 5% dextrose and water. The urine output reached 950 cc the first 24 hours.

On the second hospital day the WBC was 15,800 with 58% polymorphs. A serum calcium was reported

as 12.5 mgm% and a fasting blood sugar as 95 mgm%. The BUN was 10 mgm%, cephalin flocculation negative, and an alkaline phosphatase, 10 units. The patient had one temperature elevation to 100° orally but was comfortable and not requiring any pain medication. She was given 2000 cc 5% dextrose and normal saline and 1000 cc 5% dextrose and water. Urine output reached 1450 cc.

On the third hospital day bowel sounds were active, and the patient was passing flatus. Her abdomen was non-tender. The temperature, pulse, and respirations were normal. An amylase was reported as 165 units and a WBC as 10,000 with 55% polymorphs. The nasogastric tube was removed and the patient begun on a soft, bland, low fat diet. The jaundice was clinically receding.

Comment

It is important to determine the serum calcium level in pancreatitis. This may be decreased due to some of the ionized portion of serum calcium combining with fatty acids set free by the action of increased lipase on neutral fats. This test is useful in determining the severity of pancreatitis and in giving a prognosis. A serum calcium level of 7 mgm% generally means a severe hemorrhagic or necrotizing type of pancreatitis and is associated with very few survivors.

The fasting blood sugar may be transiently elevated during the acute phase of pancreatitis as well as being permanently elevated perhaps in late chronic pancreatitis. This transient elevation apparently results from temporary insufficiency of the insulin producing beta cells.

From the beginning of treatment this patient responded favorably. Her pulse and respirations decreased as well as her abdominal tenderness. If she had failed to improve or if her signs and symptoms had progressed, exploratory laparotomy might have been indicated because cholecystitis was suspected in addition to pancreatitis.

The return of bowel activity is the best single indication that the patient is recovering from pancreatitis. This return of peristalsis combined with normal vital signs and no abdominal tenderness in this patient permitted removal of the nasogastric tube and resumption of oral diet. Feeding must be resumed with extreme caution in these patients, since food is a potent stimulus for pancreatic secretion. Stimulants to gastric secretion such as coffee, tea, cigarettes and cola drinks are scrupulously avoided.

Hospital Course Continued

On the fourth hospital day the patient had a normal upper gastrointestinal x-ray series and a non-functioning gallbladder to a single dose (3 gms) of Telepaque®. A repeat, double dose, cholecystogram on the following day still showed a non-functioning gallbladder.

On the sixth hospital day the patient was taken to surgery and a thickened non-inflamed gallbladder was found containing multiple stones of varying size. The pancreas was diffusely enlarged, hard, and surrounded by edematous tissue. A minimal amount of fat necrosis was seen. The gallbladder was removed and an operative cholangiogram performed to search for evidence of common duct stones. The common duct was normal in size and contained no radiopacities. A drain was placed into the foramen of Winslow, brought out through a separate stab wound in the right flank, and the incision was closed.

Postoperatively the patient remained afebrile, and an amylase on the second postoperative day was 160 units. A bland diet was begun on the second postoperative day, and the remainder of the postoperative period passed uneventfully.

Comment

An upper gastrointestinal x-ray series is indicated during convalescense from pancreatitis in an attempt to determine if a pseudocyst or lesser sac collection of fluid exists.

The gallbladder frequently will not concentrate contrast material up to a few weeks after pancreatitis or other peritonitis, and yet on a later examination prove to be normal. Therefore, non-functioning of the gallbladder in this patient at this time is not sufficient evidence in itself to prove cholecystitis. Neither does the transient jaundice in this case, in itself, prove primary biliary disease since edema of the pancreas can alone produce this. However, for the prevention of future attacks of pancreatitis, biliary tract disease must be excluded. One half to two-thirds of all patients first seen with acute pancreatitis prove to have biliary tract disease. The higher figure would prevail when alcoholism, as an etiologic factor, can be excluded.

Biliary tract surgery can be safely undertaken very shortly after pancreatitis subsides, as this case illustrates. The common bile duct should be explored or a satisfactory operative cholangiogram obtained to search for stones.

The operative findings indicate that pancreatitis accounted for the acute illness in this patient. The gallbladder was involved only to the extent that cholelithiasis with chronic inflammation was present. The prognosis for complete recovery is excellent, and the chance for a recurrent attack of acute pancreatitis is remote.

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EDITORIALS

King-Anderson Bill 'Sleepers'*

THE King-Anderson Bill to provide medical aid to all persons 65 and older has pointed up the urgent necessity for citizens to become informed on legislation proposed for passage by Congress.

Here is a bill that, according to the American Medical Association, is rife with "sleepers" or "fine print," the ramifications of which have not been made available to the public.

We have seen no denials of statements made by AMA spokesmen such as Edward R. Annis, M.D., who spoke here last week. So we may assume the AMA interpretation of the bill is correct.

That we have to depend on "outside" interpretation is a sad commentary on our alertness. The press is not blameless and we will be among the first to admit that we have been remiss and that we must make the necessary effort to obtain copies of proposed legislation.

Doctor Annis said the Kerr-Mills Law, enacted by Congress in 1960 and already implemented in 38 states, gives medical aid to "senior citizens" on the basis of individual need. The federal funds for this program are administered through the states.

Medical men approve of the Kerr-Mills provision, but they are opposed to the King-Anderson Bill which links medical care for the aged with the Social Security system.

The King-Anderson Bill sponsored by the Administration would provide medical care to all persons 65 and older, including those who can well afford to pay for their own medical care. It means that all "senior citizens," millionaires and paupers alike, will share—and share alike—in receiving the bounty.

Persons 65 or older would qualify for the benefits even though they may be working for their top salaries, but persons under 65 would not qualify even though they may be retired and getting cash payments under Social Security.

Doctor Annis pointed out there are presently 17,000,000 persons 65 or older in this country. And he asked, "How many people would agree to pick up grocery bills" for them "just because they happen to have a birthday?"

Additional evidence of exaggerated and undemocratic paternalism on the part of the federal government is the Administration-given reply at a recent White House conference where there was raised the question of providing more dollars for aged persons to use for health needs.

"People cannot be trusted to prudently spend their health dollars," was the reply.

The Herald submits this smacks of impertinence, and it is an insinuation that persons lose their reasoning powers when they become 65 and should be shelved to vegetate. How about some of our leaders in all fields, including government, who have reached age 65?

Such an assertion makes one wonder if those who made it have yet reached the age of reason. And such high-handed efforts to have adopted legislation that affects every citizen of the United States is an insult to the intelligence.

In many respects we ask for this insult because we elect persons to represent us, then we fail to follow through. We neither bother to learn what questions they must decide nor how we want them to decide.

Apparently the full story of the King-Anderson health bill has not been told. The bill would require "senior citizens" to pay the first $90, or $10 per day for the first nine days of hospitalization.

There are many persons who cannot afford to pay any part of this, but there are others who are able to pay all their medical expenses who would qualify for the tax-supported care by paying the first $90.

Also, many workers earn so little they don't have to pay income taxes, yet Social Security

**We print the following editorial from the Lexington Herald of April 18, 1962 as a guest editorial.*

deductions are made from their pay checks. Thus, those (estimated at 10% of the workers) who can least afford to pay anything on their own medical bills are helping to pay for medical care for those who can afford to pay their own bills.

We have only to look at the history of Social Security to get an idea of what may be in store if this type of compulsory medical care for the aged is implemented.

Originally Social Security provided monthly cash benefits for retired workers only, and we were told Social Security would cost no more than $30 a year in taxes from the employee and from his employer, the cost rising in steps to a maximum of $90 a year each.

But before a single monthly cash benefit had been paid, Congress added survivors, dependents and disabled persons to the list qualifying for participation. Additions were made in 1939, 1950, 1958 and 1960.

And what happened to the $90 maximum cost? It has risen to $144, and economists say it must be increased to $222 by 1968 in order to continue paying the present benefit amounts.

The King-Anderson Bill limits the use of drugs to those approved by the government, a provision medical men say has crippled England's medical care under its socialization of the profession.

The bill before Congress does not provide for government payment of doctors' fees, for surgery, dental care, drugs and medicines. But, if this program is adopted, we have every reason to expect that additional government-paid services and facilities will be added and that the age bracket will be lowered for participation.

There is no reason to believe that Social Security history won't repeat itself.

Mail Order Prescriptions

IT seems that an increasing number of people, in order to avoid what they regard as excessive charges for drugs, are sending their prescriptions to discount houses in distant cities. This would appear to be a questionable form of economy.

The time consumed in having a prescription filled by mail as compared with taking it to the corner drugstore is often a significant factor in the treatment of illness. When the patient patronizes his neighborhood druggist he at least deals with a personal acquaintance and often an actual friend. This is an important factor. Shortcuts are often expensive and dangerous. Reduced rates on drugs are usually available locally, and it would certainly be more convenient and neighborly to patronize one's local pharmacy than to deal with a distant mail order house which may be of uncertain reputation or integrity.

The pharmacist has from time immemorial been a colleague and partner with the physician in the treatment of illness. Not infrequently he has occasion to call a physician and to remind him that a prescription is not entirely clear or even incorrect in the drug prescribed or the dosage directed. This is a service and safeguard which most of us as physicians have appreciated more than a few times. Such cooperation in the patient's interest should not be lightly sacrificed.

At the KSMA Meeting in September 1960, the House of Delegates approved a resolution condemning the practice of mail order merchandising of prescription drugs. A record of this action may be found on Page 1458 of the December 1960 issue of the Kentucky State Medical Journal. We record here our endorsement of this principle.

Sam A. Overstreet, M.D.



Confidential Crash Meeting on Health Care Benefits and Social Security*

WALTER R. JOHNSON, M.D.

Paducah, Ky.

Vice President (Western District)
Kentucky State Medical Association

THE confidential crash meeting on health care benefits and Social Security was held at the LaSalle Hotel, Chicago, December 19, 1961. It was a confidential meeting sponsored by a number of national agencies and was aimed at informing important representatives of these agencies of the dangers and far-reaching effects of the proposed legislation to be presented at the next session of Congress concerning health care benefits under Social Security.

I attended this meeting on the behalf of the Kentucky State Medical Association at the request of the President and the Chairman of the Board of Trustees.

The meeting was conducted by Chase Smith.

First, an excellent presentation was made of the background leading up to the present Social Security status of this country. William Morrell, executive vice president of the Continental Casualty Insurance Co., extensively reviewed up-to-date statistics concerning people covered and not covered by voluntary insurance programs and government-sponsored programs. The problem of lack of coverage is a diminishing one except for the group of individuals who can be covered by voluntary systems but do not desire to be.

Mr. Morrell further presented the ideas and concepts of the voluntary insurance systems and their ability to cover the age group over 65.

Karl Schlotterbeck, director of the United States Chamber of Commerce economic security program, presented a comprehensive analysis of what can be done by businessmen and their organizations represented at the meeting.

His discussion centered around a "do-it-yourself kit," aimed at helping preserve our voluntary systems of health and medical care. He went into detail as to the "targets," as he called them, for action. This ranged from contact of individuals in this age group, to newspaper editors, to boards of trustees of hospitals, to members of Congress and members specifically of the House Ways and Means Committee.

At the conclusion of the formal presentations, a question and answer period was held so that the around 300 individuals present could participate in the conference.

I was most interested in many of the comments since there were very few medical people present. Among the comments: "The doctors have been fighting this for years; it is time that we gave them a strong helping hand."

I had the feeling that the individuals present learned a great deal about something that they knew of only in a vague way.

The "do-it-yourself kits" were made available in large numbers to the individuals present as well as the sponsoring agencies.

Listed below are the sponsoring and cooperating national agencies that participated in this conference:

American Farm Bureau Federation; American Medical Association; American Mutual Insurance Alliance; American Nursing Homes Association; American Pharmaceutical Association; American Retail Merchants Association.

Association of Casualty and Surety Companies; Chamber of Commerce of the U. S.; Council of State Chambers of Commerce; Health Insurance Association of America; International Association of Accident and Health Underwriters.

Junior Chamber of Commerce of the U. S.; National Association of Insurance Agents; National Association of Life Underwriters; National Association of Manufacturers; National Small Business Men's Association; Pharmaceutical Manufacturers Association.

*This report was submitted at the meeting of the Board of Trustees of the Kentucky State Medical Association March 29 and authorized for publication in The Journal.

ORGANIZATION SECTION

Outstanding Speakers to Address KSMA Annual Meeting

The 1962 Annual Meeting of the Kentucky State Medical Association September 18-20 at Louisville will be addressed by a number of outstanding specialists in the field of medicine, according to a preview of the program just released by President Gaithel L. Simpson, Greenville. The scientific presentations promise to be among the finest ever presented at an Annual Meeting.

Program chairman for this year's Annual Meeting is Edmund D. Pellegrino, M.D., Lexington. Doctor Pellegrino is professor and chairman of the Department of Medicine of the University of Kentucky College of Medicine. In 1960, and again in 1961 he was editor of the special Symposium Edition of The KSMA Journal.

In addition to the guest speakers, the program features a Transatlantic Telephone Clinicopathological Conference between a group of Louisville physicians and selected British doctors. The subject of the transatlantic conference will be "Renal Disease."

There will be 14 specialty group meetings during the session. A number of outstanding scientific exhibits are planned.

It is expected that there will be a record attendance and Kentucky physicians are urged to make plans early to be at the meeting.

Panel discussions will be presented on the following subjects: "Management of Heart Disease in Pregnancy"; "Management of Thoracic Emergencies"; "The General Aspects of Emotional Problems." There will also be a panel on "Athetic Injuries."

Doctor Simpson provided biographical information on two of the speakers who will be featured at the meeting.

Edward Gall, M.D., Cincinnati, will address the Thursday morning session on a subject to be announced.

Doctor Gall is director of pathology at the Cincinnati General Hospital and professor of pathology and chairman of the Department of Pathology at the University of Cincinnati.

He was graduated from Tulane University Medical School in 1931. He became director of laboratories at Bethesda Hospital, Cincinnati, in 1941 and served in that capacity until his appointment in 1948 as assistant professor of pathology at the University of Cincinnati College of Medicine. Doctor Gall was named to the chair of Mary M. Emery professor of pathology at Cincinnati that same year and has served as director of laboratories at Cincinnati General Hospital since 1958.



Doctor Gall



Doctor Mendelson

He is editor-in-chief of the American Journal of Pathology and is widely recognized for his research investigation in the area of lymphomas.

Curtis Lester Mendelson, M.D., F.A.C.S., F.A.C.O.G., Abaco, Bahamas, will be a participant in the panel discussion on "Management of Heart Disease in Pregnancy," the morning of September 18. In the afternoon he will address the Kentucky Obstetrical-Gynecological Society on "Medical Care, Cardiovascular Surgery and Obstetric Management in the Pregnancy Cardiac Patient."

Doctor Mendelson is an internationally known authority on cardiac physiology in pregnancy.

He is former associate professor of clinical obstetrics and gynecology at Cornell University Medical College, New York, former attending obstetrician and gynecologist at New York Hospital; former director of the Obstetric Cardiac Clinic at New York Lying-In Hospital; former professor of obstetrics and gynecology at New Yok Polyclinic Medical School; former attending obstetrician and gynecologist at New York Polyclinic Medical School and former consultant in obstetrics to the New York City Health Department.

Doctor Mendelson is author of the monograph: "Cardiac Disease in Pregnancy" and of numerous articles on cardiac physiology during pregnancy.

AMA Headquarters Tour Planned

Special guided tours of the headquarters of the American Medical Association will be a feature of the 111th Annual Meeting at Chicago, June 24-28. A special corps of trained guides will be available throughout the week, June 25-29 from 9 a.m. to 4 p.m., to escort visiting physicians and other guests through the building.

Council on Scientific Assembly Releases First Draft of Program for 1962 Annual Meeting September 18, 19, 20

The first draft of the 1962 Kentucky State Medical Association Annual Meeting program has been released by Gaithel L. Simpson, M.D., Greenville, KSMA president and chairman of the Council on Scientific Assembly and Arrangements.

Edmund D. Pellegrino, M.D., Lexington, is chairman of the program committee.

The meeting will be held in Louisville September 18, 19 and 20. The tentative program follows:

Tuesday, September 18

A.M.

8:45 **Opening Ceremonies**

9:00 Panel Discussion: **"Management of Heart Disease in Pregnancy"**
Walter S. Coe, M.D., Louisville, Moderator
Medical Aspects: Samuel H. Sandifer, M.D., Fort Knox
Obstetrical Aspects: Curtis L. Mendelson, Abaco, Bahamas
Anesthesiological Aspects: Ray T. Parmley, M.D., Wichita, Kan.

10:30 **Visit Exhibits**

11:00 **President's Address**
Gaithel L. Simpson, M.D., Greenville

11:20 James Halstead, M.D., Detroit, Mich.
Subject: **"Some Important Health Problems in Underdeveloped Countries"**

11:40 Jose J. Centurion, M.D., Department of Medicine, University of Miami, and Governor Pro Tem for Cuba for the American College of Physicians
Subject: **"Some Aspects of the Cuban Refugee Physician Problem"**

12:00 N. **Luncheon**

P.M.

2:00-4:30 **Specialty Group Meetings:**
Kentucky Anesthesiology Society
Kentucky Chapter, American College of Chest Physicians
Kentucky Obstetrical-Gynecological Society
Kentucky Chapter, American Academy of Pediatrics
Kentucky Chapter, American College of Physicians
Kentucky Chapter, American College of Surgeons
Kentucky Radiological Society
Kentucky Orthopaedic Society

Wednesday, September 19

A.M.

9:00 Panel Discussion: **"Management of Thoracic Emergencies"**
Jerome C. Cohn, M.D., Lexington, Moderator
Medical Aspects: R. Drew Miller, M.D., Rochester, Minn.
Surgical Aspects: E. Stanley Crawford, M.D., Houston, Tex.
Radiological Aspects: William R. Eyler, M.D., Detroit, Mich.
Pediatric Aspects: William Silverman, M.D., New York City

10:30 **Visit Exhibits**

11:00 Alvin L. Morris, D.M.D., Lexington, Dean, University of Kentucky School of Dentistry
Subject: **"Developments at the University of Kentucky School of Dentistry"**

11:20 Gerald O'Dell, M.D., Richmond, Va.
Subject: **"Hyperbilirubinemia in the Neo-Natal Period"**

11:50 **President's Luncheon**

P.M.

2:00 **Transatlantic Clinicopatholocial Conference**
Subject: **"Renal Disease"**

3:30 Panel Discussion: **"The General Aspects of Emotional Problems"**
S. Spafford Ackerly, M.D., Louisville, Moderator
The Internists' View: Richardson K. Noback, M.D., Lexington
The Psychiatric View: John C. Nemiah, M.D., Boston, Mass.
Musculoskeletal Aspects: Joseph L. Goldner, M.D., Durham, N. C.
Headache and Vertigo: Francis L. Lederer, M.D., Richmond, Va.

Thursday, September 20

A.M.

9:00 Panel Discussion: **"Athletic Injuries"**
O. B. Murphy, M.D., Lexington, Moderator

10:30 **Intermission**

11:00 Howard Shaughnessey, Ph. D., Chicago
Subject: **"E Coli Diarrheas in Children"**

11:20 Edward Gall, M.D., Cincinnati, Ohio
Subject: To Be Announced

11:40 Mac Roy Gasque, M.D., New York City
Subject: To Be Announced

12:00 N. **Luncheon**

P.M.

2:00-5:00 **Specialty Group Meetings:**
Kentucky EEN&T Society
Kentucky Chapter, American Academy of General Practice
Kentucky Industrial Medical Association
Kentucky Society of Pathologists
Kentucky Psychiatric Association
Kentucky Public Health Association

Dr. Gardner on "Eyewitness" Over CBS-TV in June

Hoyt D. Gardner, M.D., Louisville, is scheduled to appear as a panelist on the program "Eyewitness" over the CBS television network in mid-June. Topic discussed is, "King Anderson Bill and Other Aspects of Financing Medical Care for the Aged."

The hour-long program was taped on May 23 for showing on "Eyewitness" and carried live on that date on local Indianapolis TV and radio stations. Each panelist spoke for about 10 minutes.

More than 700 physicians and their patients from the area attended the panel discussion. A question and answer period followed with questions coming from members of the audience.

Other members of the panel were: Don Woods, M.D., president-elect of the Marion County (Ind.) Medical Society, the president of the Indianapolis Chamber of Commerce, an Indiana Farm Bureau executive and an insurance executive.

The Indiana State Medical Association also taped the program.

Doctor Thurber Joins Health Dept.

Donald B. Thurber, M.D., Louisville, has joined the Kentucky Department of Health at Frankfort as a public health physician. He was formerly with the General Electric Company at Louisville as a staff physician.

Loans for Nine Approved By Rural Medical Scholarship Fund

Loans of $1,000 each were approved for nine medical students by the Rural Kentucky Medical Scholarship Fund board of trustees meeting May 2 at the new Headquarters Office Building of the Kentucky State Medical Association.

Applications from seven other students were deferred for further study.

Approved for loans were: Lincoln W. Henderson, Louisville, University of Louisville School of Medicine; Richard M. Hutson, Murray, Vanderbilt University School of Medicine, and from the University of Kentucky College of Medicine: Stanley Leroy Catron, Alpha; Rachel R. Eubank, Tompkinsville; Martha Charlene Hill, Williamsburg; Frank Douglas Scutchfield, Martin; John E. White, Beauty; Charles O. Wilson, Jr., Lexington, and Wallace B. Sullivan, Stearns.

Students agreeing to practice in the ten most critical counties in need of physicians will have one loan cancelled for each year of practice given. These counties are: Wolfe, Powell, Elliott, Martin, Magoffin, Knott, Breathitt, Lesie, Owsley and Jackson.

Nineteen recipients of the Fund completed internship last July and located in a qualifying area or entered military service. Those going into service will be delayed two years starting their practice. Projecting availability of rural scholarship students presently in medical school or taking internship—16 will be ready for practice in July 1962, 32 in July 1963, 20 in July 1964 and 11 in July 1965.

According to Bobbie R. Grogan, executive secretary of the Fund, loans have thus far been made to 223 students representing 76 counties and recipients are now practicing in 54 counties. The loans are made to qualified students for seven years at 2% simple interest repayable after they have begun practice in rural Kentucky counties.

The Fund, which now contains $343,117, was started in 1946. State allocations to the fund have amounted to $175,000 and Governor Combs has earmarked $60,000 more for the next two years.

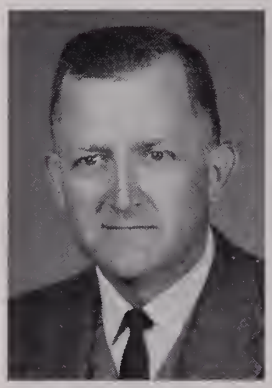
U. of K. Hospital Opens Doors

The first six patients were admitted to the University of Kentucky Hospital April 24. Opening day ceremonies were held in the Hospital auditorium. All six patients were referred to the hospital by private physicians.

Regular charges for admitted patients will be $15 a day in a four-bed room; $19 in a two-bed room and $26 in a private room. The intensive care unit will cost $32 a day; pediatric beds are $15. The outpatient clinic will charge $7.50 for use of the emergency room; $4 for the first clinic visit and $2 for a return clinic visit.

Doctor Whayne Is President-Elect of Kentucky Academy

Harry U. Whayne, Jr., M.D., Murray, was named president-elect of the Kentucky Academy of General Practice at the annual meeting and 11th annual scientific assembly May 7-11 at the Kentucky Hotel, Louisville. J. Sankey Williams, M.D., Nicholasville, took office as president. A total of 863 attended the sessions of whom 466 were doctors.



Doctor Whayne

Denzil G. Barker, M.D., Hindman, was named Kentucky's "general practitioner of the year." Doctor Barker was graduated from the Tulane University School of Medicine in 1942 and served his internship at Southern Pacific General Hospital at San Francisco. He began his practice in Kentucky at Wayland in 1946 after military service and moved to Hindman a year later. As chairman of the Knott County Board of Health he was one of the leaders in setting up a new health center at Hindman.

Doctor Whayne was graduated from Tulane University School of Medicine in 1950. He interned at Walter Reed General Hospital, Washington, D.C.



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Research in the Service of Medicine

Before entering medical school he worked for two years in the Gorgas Hospital, in the Panama Canal Zone and served after that for four years in the Army. Doctor Whayne practiced at Baton Rouge, La., and Fort Worth, Tex., before setting up his practice in Murray.

Regional vice presidents elected by the KAGP are as follows: Region I, George C. McClain, M.D., Benton; II, Stuart M. Hunter, M.D., Louisville; III, Michael M. Hall, M.D., Campbellsville; IV, Enos T. Smith, Somerset. Robert M. Sirkle, M.D., Lexington, was renamed secretary, and Roy G. Wilson, M.D., Campbellsville, treasurer. Charles W. Justice, M.D., Ludlow, was named District 8 director replacing Melvin J. Weber, M.D., also of Ludlow.

Patrick J. Murphy, M.D., Lebanon Junction, was renamed speaker of the Congress of Delegates and James W. Davis, M.D., Louisville, was named vice speaker. Frank L. Duncan, M.D., Monticello, was named delegate to the AAGP and Doctor Sirkle, alternate.

Selective Service Deferment Of Residents, Interns

The American Hospital Association has prepared and distributed an informational sheet on the Selective Service deferment of residents and interns. The information, which concerns the military service of physicians, is dated March 1962. In part:

There are a number of steps which both residency candidates and hospitals could and should take to avoid unnecessary disruption of training programs:

1. Prospective residents will be automatically classified 1-A upon completion of internship. It is essential that the prospective resident notify the proper Area Board about his appointment. The proper Area Board is that which has jurisdiction over the locale of the hospital to which he is appointed. Selective Service officials emphasize that such notification of the Area Board in no way will reflect on the resident's status with his own local board. If the prospective resident waits until he receives a 1-A classification notice from his local board, he has only 10 days in which to make an appeal. Failure to appeal within the 10-day period will nullify his right to appeal.

2. Hospitals should ask all candidates for residency positions to furnish their Selective Service numbers, their draft classifications and the addresses of their local boards. Selective Service officials recommend that the hospital notify the respective local boards of the effective dates of each resident's appointment. This notification is not an appeal, but it informs local boards of facts which may help in making a judgment on a draft candidate's change of status. An appeal from a draft status should be directed to the Area Board. The appointing hospital may, of course, support the prospective resident's appeal by letters to the Area Board.

3. Because the present national emergency is likely to be of extended duration, Selective Service officials urge hospitals to consider carefully the draft status of each prospective resident. It is recommended that, to the extent feasible, a hospital appoint draft-exempt candidates in sufficient proportion so that continuity of its residency program may be maintained.

Doctor Smith Resigns

Marjorie K. Smith, M.D., Louisville, has resigned effective September 1 as medical director of the Commission For Handicapped Children. She is planning to return to New York City to work for the Bureau of School Health. Doctor Smith was with that agency for five years before taking the Kentucky post in October 1958.

AMPAC Banquet To Be June 24 Preceding AMA Session

Senator John G. Tower of Texas and Representative Harold B. McSween of Louisiana will be speakers at the $25-a-plate banquet of the American Medical Political Action Committee Sunday, June 24 in the Grand Ballroom of the Palmer House, Chicago, just prior to opening of the annual meeting of the American Medical Association. More than 750 persons are expected to attend.

Gunnar Gundersen, M.D., AMPAC's chairman, said many physicians and their wives planning to attend the 111th annual meeting of the AMA at Chicago June 24-28, have decided to go to Chicago early enough to attend the banquet. There will be a closed meeting of AMPAC's National Advisory Committee at which a representative of every state will be present. This will be followed by a working session on political education and action which will be open. The banquet concludes the day's program.

KEMPAC Holds First Public Meet At Louisville May 14

The Kentucky Educational Medical Political Action Committee held its first public session the evening of May 14 in the Medical Arts Building, Louisville. Hoyt D. Gardner, M.D., Louisville, secretary-treasurer of KEMPAC, which is headed by George P. Archer, M.D., Prestonsburg, chairman of the group's board of directors, explained that KEMPAC was organized in January under sponsorship of the Kentucky State Medical Association.

It is open to physicians, their families and employees.

Among those addressing the public session were: M. G. Snyder, candidate for the Republican nomination of U.S. representative, and Jefferson County Judge Marlow W. Cook.

Doctor Gardner said the Kentucky group is affiliated with AMPAC and that it has two purposes: To help members understand political issues and to organize its members "as an effective political action group." He said it will function independently of all medical groups and that while other medical organizations may contribute to its educational activity, its political program must be supported only by contributions from individuals.

A later meeting is planned when Democratic candidates will appear.

Kentucky C. of C. Opposes Medical Care Plan

"The Kentucky Chamber of Commerce views legislation such as the Administration's medical care under Social Security plan as clearly within the framework of socialized medicine and a measure which would further erode the personal freedom and liberty of Americans," according to a statement May 10 by J. C. Zimmerman, executive vice president of the Chamber.

He said the Chamber specifically views passage of the proposed King-Anderson legislation not only as a program of socialism but as a governmental device



Pictured at the annual luncheon for senior medical students of the University of Louisville at the Blue Cross-Blue Shield Office, May 11, attended by 111. Special guests were: Sa n A. Overstreet, M.D.; Hoyt D. Gardner, M.D.; H. Hart Hagan, M.D.; Everett H. Baker, M.D.; Stanley Simmons, M.D., and Ernest Speckman, Lincoln Income Life Insurance Co. Pictured here, left to right, Harry Lehman, executive secretary, Jefferson County Medical Society; Don Mansfield, president, senior medical class; Don W. Giffen, vice president, Blue Cross Hospital Plan, Inc.; Doctor Hagan; D. Lane Tynes, president, Blue Cross; Doctor Gardner; J. Ed McConnell, vice president, Blue Cross; Mr. Speckman; Doctor Overstreet; Doctor Simmons; J. Ray Ingram, vice president, Blue Cross; J. P. Sanford, executive secretary, Kentucky State Medical Association; Hasty W. Riddle, executive director, Kentucky Hospital Association.

which would further dilute the earnings of all Americans, leaving them with very little to meet their basic needs in supporting families, buying homes and educating children.

Mr. Zimmerman noted the high degree of controversy which the proposed medical care program has touched off and stated that the Chamber looks upon socialized medicine as a measure which would lower the existing and established high standards of medical practice and would substitute a regimented second rate medical service.

AMA's Blasingame Advocates Ribicoff Investigation

F. J. L. Blasingame, M.D., executive vice president of the American Medical Association, Chicago, May 9 wired Attorney General Robert Kennedy and urged an investigation of whether Abraham Ribicoff, secretary of the Department of Health, Education and Welfare, had committed a criminal act in publishing a booklet on health care of the aged.

Doctor Blasingame charged that the booklet "lobbies for enactment of the King-Anderson Bill" and that the Department "has used tax funds . . . to propagandize for a bill which many people and many groups have vigorously opposed. Under the law, the publishing of this kind of booklet without Congressional authority is a criminal act, punishable by fine or imprisonment, or both, and removal from office.

He said that Congress had not authorized its publication and that Congressman John W. Byrnes (R., Wis.) has protested the spending of tax funds for the booklet. His telegram to the Attorney-General said in part: "I urge you to make a thorough investigation into this matter and to institute proper measures if Federal laws have been broken."

Guardianship Plan Set Up By Mental Health Dept.

The Kentucky Department of Mental Health has begun operation of a guardianship section which permits the Department to be declared guardian for patients with no family or other person willing to serve in this capacity. The new section was established by an act of the 1960 General Assembly.

According to Mental Health Commissioner Harold L. McPheeters, M. D., this program will expedite home-going plans for patients who do not need hospital facilities, for in the past many patients have been blocked from hospital-release because they had no funds, homes nor anyone interested in serving as guardians.

The law allows for prompt appointment of a committee and for the full amount of public assistance to go to the individual rather than a percentage of it going to a committee. The Department of Mental Health can be appointed guardian only in those cases where a patient has been found incompetent, when he has been committed to one of the four State mental hospitals and when no one else is available. When a patient is legally restored the committeeship ceases.

Doctor Bate with AAGP

Thomas H. Bate, M.D., 55, has been named director of medical education on the administrative staff of the American Academy of General Practice, Kansas City, Mo. He will also serve as secretary of the commission on education. Charles E. Nyberg, secretary of the commission for the last 12 years, has been named assistant executive director. Doctor Bate has most recently been on the staff of the American College of Surgeons.

U of L's Doctor Brodsky Wins Award; Other Grants Received

William A. Brodsky, M.D., professor of experimental medicine at the University of Louisville School of Medicine, has won a career-research award from the United States Public Health Service. This is the highest award for research granted in this country. It is a lifetime grant and will amount to $105,674 during the first five years.

Doctor Brodsky's research deals in the functions of the kidney and his experiments have been with dogs and with kidney systems in isolated living membranes such as bladders of turtles. Doctor Brodsky was graduated from Temple University School of Medicine, did his residence work in pediatrics at the University of Pennsylvania and later trained at the University of Cincinnati. He went with the U. of L. in 1951 and became a full professor there in 1959.

The American Heart Association has made fellowship awards totaling $60,800 to four U. of L. Medical School faculty members and to one research fellow.

Gaspar Carrasquer, M.D., instructor in medicine, an established investigator, received his first Heart Association award. He is studying the activity of the kidney.

Richard Duncan Dallam, associate professor of biochemistry, received a continuing established-investigator award for studies in the biochemical mechanism of energy transfer.

Warren H. Dennis, instructor in community health and associate in physiology, received a continuing established-investigator award for his studies of the fine wall which surrounds all living cells.

Agamemnon Despopoulos, M.D., received another established-investigator award for studies on how substances such as drugs pass through cell walls.

Nestor J. Carlisky received a first-time research-fellow award for his study in kidney tubules in relation to urea formation.

New Scholarship Program

The Medical Foundation of the Jefferson County Medical Society has made a grant of $1,575 to the U. of L. School of Medicine making possible a new scholarship program. It will pay partial tuition for two high-ranking medical students during the academic year beginning in September of this year.

The School's committee on student affairs will select two recipients on the basis of scholarship alone.
County Society Reports

A postgraduate course in "Cardiopulmonary Problems in Children" will be sponsored by the Council on Postgraduate Medical Education, American College of Chest Physicians, at the Edgewater Beach Hotel, Chicago, July 23-27. Tuition is $75 for College members and $100 for non-members. Additional information may be obtained from Murray Kornfeld, 112 E. Chestnut St., Chicago 11.

Tuberculosis Groups Elect

Asa Barnes, M.D., Louisville, was elected president of the Kentucky Tuberculosis Association at the annual meeting April 26-27 at the Sheraton-Seelbach Hotel, Louisville. Edward N. Maxwell, M.D., Louisville, was named first vice president; Robert S. McGinnis, Sr., Owensboro, second vice president; Turner A. Woodson, M.D., Louisville, third vice president; Mrs. Chapman Jennings, Paducah, secretary; Earl R. Gernert, M.D., Louisville, treasurer.

Nathan Levene, M. D., Louisville, took office as president of the Kentucky Thoracic Society, and Grover B. Sanders, M.D., Louisville, was named president-elect. Lloyd D. Mayer, M.D., Lexington, was elected secretary-treasurer of the Society, and William H. Anderson, M.D., Harlan, was named representative to the American Thoracic Society.

Ky. Anesthesiologists Meet

Three speakers addressed the annual Lexington spring meeting of the Kentucky Society of Anesthesiologists April 15. Saul Rubin, M.D., Lexington, presided at the meeting.

William Hamelberg, M.D., professor of anesthesiology at Ohio State University, discussed the anesthetic management of patients with severe heart disease; Louis Franklin, M.D., associate professor of anesthesia at Children's Hospital, Columbus, Ohio, discussed the fluid management of the seriously ill child, and Eugene Conners, M.D., professor of anesthesia at the University of Louisville School of Medicine, discussed anesthetic management of patients with crush injuries of the chest.

Technologists Elect Officers

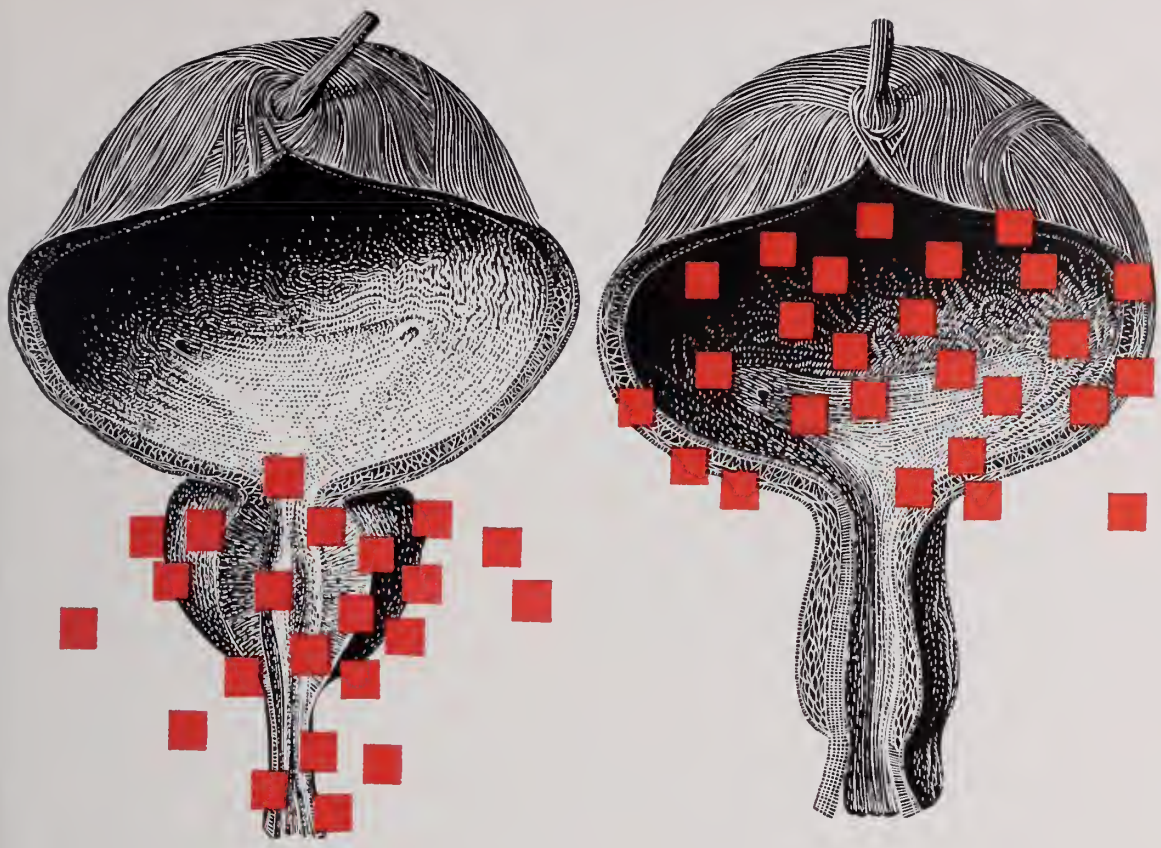
Bill Cooley, Louisville, was named president-elect of the Kentucky State Society of Medical Technologists at the state convention April 28-29 at Louisville. Taking office as president was Hugh Roberts, also of Louisville.

Other officers elected: Secretary, Helen Sehr, Louisville; treasurer, Alma Hargrove, Louisville; named to the board of directors, Malcolm Grinstead, Elizabethtown, and nominations chairman, Oscar Alton, Louisville.

Doctor Evans Is W. Va. Editor

George F. Evans, M.D., Clarksburg, W. Va., has been named editor of The West Virginia Medical Journal, official publication of the West Virginia State Medical Association. Doctor Evans succeeds the late Walter E. Vest, M.D., Huntington, who served as editor from 1937 until his death January 28.

Doctor Evans is a native of Canada and received his medical degree from McGill University at Montreal. He was president of the West Virginia Association in 1958-59.



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OPPORTUNITIES

From The

KSMA Postgraduate Medical Education Office

Grant From Geigy Pharmaceuticals

Geigy Pharmaceuticals of Ardsley, New York, has made a grant of $500 to the Postgraduate Medical Education Office of the Kentucky State Medical Association to be used to further its postgraduate educational program.

The Kentucky Postgraduate Medical Education Fund has been ruled exempt from the federal income tax thus making contributions to it deductible by the donor. Gifts or transfers to the fund are deductible for federal estate and gift tax purposes.

In Memoriam

In Kentucky

JUNE

14 KAGP Seminar, Henderson, Ky.

JULY

12 KAGP Seminar, Country Club, Paintsville, Ky.

19-20 KAGP Seminar, Kentucky Dam Village, Gilbertsville, Ky.

AUGUST

1 KAGP Seminar, Sue Bennett College, London, Ky.

9 KAGP Seminar, Bardstown, Ky.

19 KAGP Seminar, Lexington, Ky.

23 KAGP Seminar, Diamond Caverns Hotel, Park City, Ky.

Surrounding States

JULY

22 Symposium, **Inflammation, Mental Depression,** Blue Ridge Chapter of General Practice, Hotel Roanoke, Roanoke, Va.

AUGUST

23-25 West Virginia State Medical Association, White Sulphur Springs, W. Va.

Is your group holding a meeting or sponsoring a speaker or an activity that you believe would interest others in the profession?

Are you looking for a speaker for your next monthly session or annual meeting?

We can help—if you will get in touch with the Postgraduate Office of the Kentucky State Medical Association, 3532 Janet Avenue, Louisville 5, Ky. Or phone us: GL 4-6324.

Ky. Farm Bureau President Named

Burl St. Clair, Falls of Rough, Ky., president of the Kentucky Farm Bureau Federation and a member of the American Farm Bureau Federation board of directors, has been appointed to the Advisory Committee to the Council on Rural Health of the American Medical Association.

The annual meeting of the Council will be held September 7-8 at the Drake Hotel in Chicago. F. A. Humphrey, M.D., Fort Collins, Col., is chairman of the AMA Council on Rural Health.

Marine Hospital Name Changed

The name of the Louisville Marine Hospital is being changed to Louisville Memorial Hospital for Chronic Illness, according to William D. Price, Jr., new administrator.

Doctor Ice To Head Clinic

John F. Ice, M.D., assistant medical director of the Child Guidance Clinic, Louisville, since last summer, will become medical director of the Clinic July 1. He replaces S. Spafford Ackerly, M.D., who has been director for 30 years and will remain on the psychiatric staff of the clinic and will continue as head of the Department of Psychiatry at the University of Louisville School of Medicine.

KSMA Numbers New Members

The Kentucky State Medical Association announces the following new members: D. E. Edger, M.D.; F. C. Spencer, M.D., and Arthur Lieber, M.D., all of Lexington; I. K. Edwards, M.D.; Frederick Sigda, M.D., and R. F. Bettasso, M.D., all of Madisonville.

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If you are now prescribing the newer corticosteroids— such as triamcinolone, betamethasone, paramethasone or another brand of dexamethasone, because of reduced risk of sodium and fluid retention, potassium depletion, or disturbance of glucose metabolism – you can obtain all of these benefits with HEXADROL, at marked savings – yet with complete assurance of unsurpassed quality and therapeutic effect.

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Columbia Auditorium — **Louisville, Kentucky** — **September 18, 19, 20**

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J. ALEX HALLER, M.D., Chairman

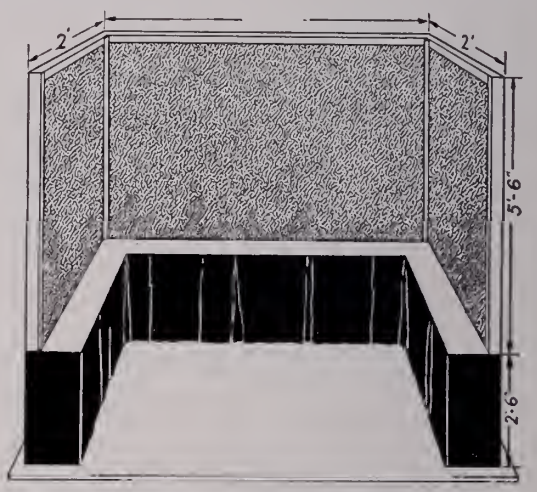
Committee on Scientific Exhibits

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Louisville 2, Kentucky

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1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank, not to exceed 100 words, which will be used in the program.)

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

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KSMA Council, Committee Reports

Council on Allied Professions and Related Groups

J. Farra Van Meter, M.D., Chairman

Campbell House, Lexington **May 3, 1962**

The Council on Allied Professions and Related Groups met May 3, at the Campbell House, Lexington.

Several referrals from the 1961 House of Delegates were discussed and directed to the proper Committees under the Council for implementation. The Council also discussed future goals of its Committees. Logan Gragg, M.D., gave a report on the Conference On Mental Health held in Chicago February 2-3, 1962.

One recommendation was made to the KSMA Board of Trustees.

School Health Committee

R. E. Davis, M.D., Chairman

Campbell House, Lexington **April 5, 1962**

The second meeting of the School Health Committee for the associational year was held Thursday, April 5, at the Campbell house in Lexington.

The Committee made plans for the first in a series of regional conferences on the prevention of athletic injuries for 1962 in Kentucky. The first conference was set for April 27 at the Daviess County High School at Owensboro.

Other topics discussed were the distribution of a Medicine in Sports News-letter and safety pamphlets; the youth physical fitness program in the schools in Kentucky; an athletic medicine symposium at the annual meeting; a postgraduate course on athletic injuries; seminars for physicians on athletic medicine and the School Health Council.

Following a brief discussion of the youth physical fitness program in Kentucky, the Committee passed a recommendation that the KSMA strongly endorse the youth physical fitness program in Kentucky as outlined in the booklet, "Youth Physical Fitness," and that a resolution to this effect be drawn up and presented to the 1962 House of Delegates of KSMA.

Public Health Committee

Delmas M. Clardy, M.D., Chairman

Brown Hotel, Louisville **March 8, 1962**

The Public Health Committee met March 8 at the Brown Hotel, Louisville, to plan this year's Immunization Week Program.

The Committee, in addition to developing ways and means of presenting and publicizing the 1962 Immunization Week program, discussed several AMA House of Delegates Reports, the problem of alcoholism, and the Campbell House conference on tuberculosis.

Two recommendations were passed by the Committee, one on Immunization and the other on holding a seminar on the relationship of air pollution and smoking to lung cancer at the KSMA Annual Meeting.

Committee on Aging

Earl P. Oliver, M.D., Chairman

Headquarters Office Bldg., Louisville **April 17, 1962**

The KSMA Committee on Aging met Thursday, April 17, in the KSMA Headquarters Office Building, Louisville.

J. Duffy Hancock, M.D., and R. O. Joplin, M.D., submitted a combined report of the recent meeting of the Governor's Commission on Aging and Doctor Oliver gave a report on the Second National Conference to the Joint Council to Improve the Health Care of the Aged.

The Committee discussed the American Medical Association's position on retirement, the AMA Service to Senior Citizen Groups and the Blue Shield Senior Citizens Program. In addition to this, the Committee discussed ways and means of distributing four booklets on aging. It was recommended that a booth be set up at the Kentucky Academy of General Practice meeting in Louisville May 9-11 to distribute these attractive booklets.

Postgraduate Medical Education Committee

Walter S. Coe, M.D., Chairman

Headquarters Office Bldg., Louisville **April 19, 1962**

The Postgraduage Medical Education Committee of KSMA held its second meeting this year Thursday, April 19, in the KSMA Headquarters Office Building, Louisville.

William Harris, director of the Postgraduate Medical Education Office, gave a report on PGME activities since the last meeting. William Anderson, M.D., submitted to the Committee a proposed program of Hospital Teaching Sessions.

The Committee discussed continuation of PGME in Kentucky as a coordinated effort, financing the programs developed by PGME Office and new publicity ideas to encourage attendance at the PGME courses.

General Practice Committee

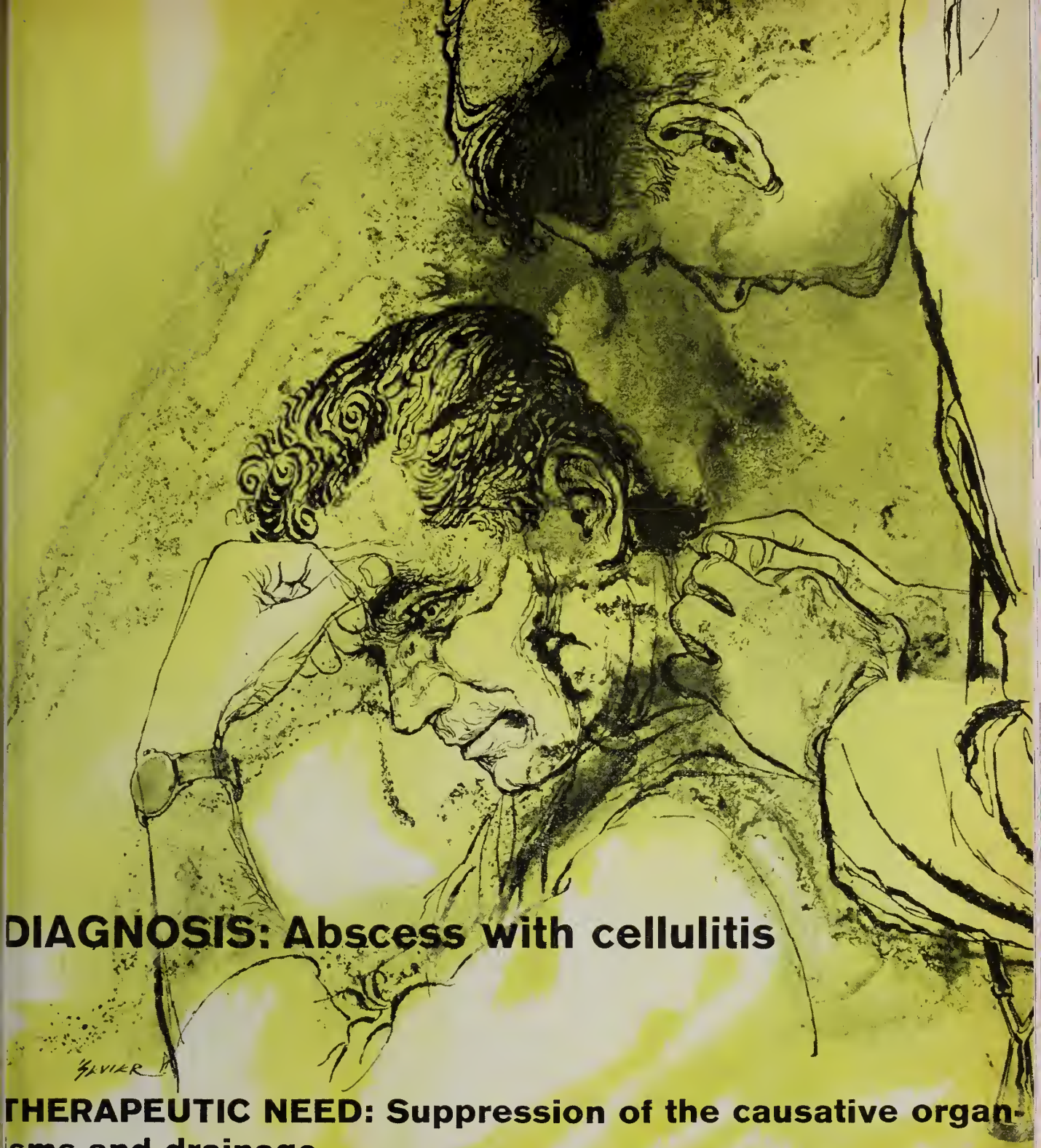
Homer B. Martin, M.D., Chairman

Kentucky Hotel, Louisville **May 9, 1962**

The first meeting of the KSMA General Practice Committee was held Wednesday, May 9, in the Kentucky Hotel, Louisville.

A discussion was held on the five recommendations of the General Practice Committee in the report of the Council on Medical Education and Hospitals to the 1961 House of Delegates. These recommendations were referred back to the General Practice Committee for implementation.

The Committee reviewed a questionnaire prepared by Doctor Martin. The purpose of the questionnaire is to survey the State's general practitioners so as possibly to improve general practice teaching in the State's medical schools.



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Committee Reports

Council on Medical Education And Hospitals

Walter S. Coe, M.D., Chairman

Headquarters Office Bldg., Louisville **April 26, 1962**

The KSMA Council on Medical Education and Hospitals met for the second time during the associational year April 26 at the KSMA Headquarters Office Building, Louisville.

The Council discussed the approved recommendation to set up an award to Medical School Faculty Members and directed the Headquarters Office to write to the Deans of the two Medical Schools advising them of the action taken by the Board of Trustees.

Hollis Johnson, M.D., gave a report of a Council Sub-Committee which was appointed to study the matter of relations with osteopathic physicians. J. B. Holloway, M.D., gave a report of the Hospital Committee and Doctor Coe gave a report of the PGME Committee activities.

Three recommendations were made to the KSMA Executive Committee.

Tuberculosis Committee

Shelby Hicks, M.D., Chairman

Headquarters Office Bldg., Louisville **April 25, 1962**

The Tuberculosis Committee met for the first time during this associational year Thursday, April 25, in the KSMA Headquarters Office Building, Louisville.

In addition to formulating this year's report to the KSMA House of Delegates, the Committee discussed tuberculosis locked facilities and commitment procedures and the State Department of Health mobile x-ray units.

Emergency Medical Services Committee

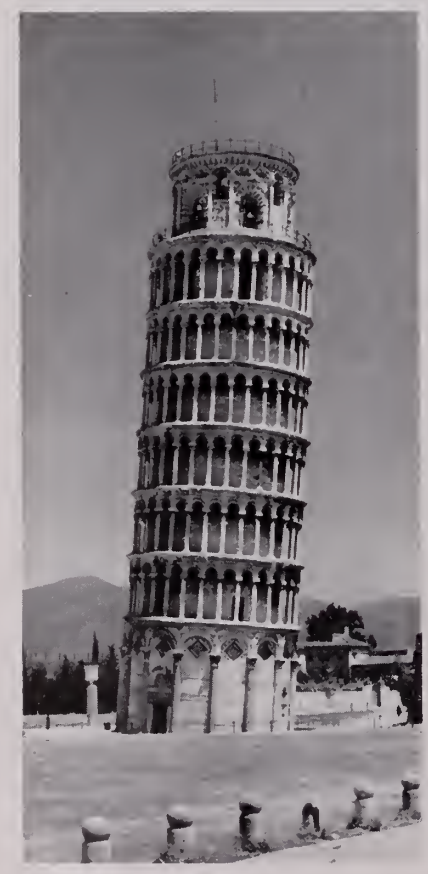
William T. Rumage, Jr., M.D., Chairman

KSMA Headquarters Office, Louisville **March 29, 1962**

The Emergency Medical Services Committee held its second meeting of the Associational year Thursday, March 29, in the KSMA Headquarters Office, Louisville.

The Committee discussed additional distribution of a first aid supplies list for fallout shelters, assistance by the Kentucky Flying Physicians Association in the State Civil Defense Program, progress and future plans in the medical self-help training program in Kentucky, a special issue of the KSMA Journal dealing with Civil Defense, and the proposal of setting up on display a 200-bed mobile hospital at the 1962 Annual Meeting.

Russell E. Teague, M.D., commissioner of health, and Forrest Stokes, U.S. Public Health Service, were guests of the committee and participated in the discussion of the medical self-help training program in Kentucky and the 200-bed mobile hospital proposal.



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1. *Methyl-Testerone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No.2, February 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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County Society Reports

McCracken County

Robert W. Noyes, M.D., professor of obstetrics and gynecology at Vanderbilt University School of Medicine, was guest speaker at the April 25 meeting, discussing "The Endometrium and Fertility."

The Society unanimously passed a motion authorizing its public relations committee to use advertising in newspapers and television during May.

At the March 28 meeting, the guest speaker was Hollis Johnson, M.D., Louisville, psychiatrist, who discussed Hypochondriasis.

The Blue Shield National Senior Citizens Program was discussed and a motion passed approving adoption of the program provided that individual doctors can choose to be either participating or non-participating. Members were urged to join KEMPAC and AMPAC and also to write letters to key people on the House Ways and Means Committee opposing the King-Anderson proposed legislation.

U. of L. Chapter Elects Officers

The University of Louisville School of Medicine Chapter of the Student AMA has elected the following new officers: President, Jerry Buchanan; vice president, Norman Edwards; secretary-treasurer, Mary Osborne.

Licensed Practical Nurses Elect

Elizabeth Jenkins, Lyndon, was re-elected president of the Kentucky State Association of Licensed Practical Nurses at the 14th annual convention, April 26-28 at Louisville. First vice president is Eugene Lesieur, Harlan; elected second vice president, Mary Begley, Lexington; re-elected treasurer, Lillian Webb, Danville; assistant treasurer, Elizabeth Satchell, Lexington. New directors are: Agnes Cropper, Louisville; Virginia Draughon, Bowling Green, and chairman of the council of presidents, Rebecca Fritts, Marion. Mary F. McWilliams, Louisville, is executive secretary.

A symposium on "The Clinical Impact of a Quarter Century of Cancer Research" will be a feature at the 1962 annual session of the American Cancer Society in the Biltmore Hotel, New York City, October 22-23, 1962. This symposium is in recognition of Cancer Progress Year, 1962 being the 25th anniversary of the National Cancer Institute. Other symposiums will deal with: "Causation of Cancer," Biological Aspects of Cancer," "Detection, Diagnosis and Treatment of Cancer."

Russell L. Browning, M.D., has started practice at Lynch, Ky., in association with the Cumberland Valley Medical Group. Doctor Browning was graduated from the University of Tennessee Medical School in 1960. He interned at the John Gaston Hospital.

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Associate Director

Student AMA

University of Louisville
Students Attend National Meeting

The 12th annual convention of the Student American Medical Association was held May 9-13 in Washington, D.C. University of Louisville School of Medicine SAMA representatives attending were Terry Davis, delegate to the House, sophomore; Stephen Blackman, alternate delegate, freshman; Jerry Sutkamp, member of the SAMA executive council, junior; and Olson Huff, president of the SAMA executive council, senior.

Notable guest speakers to the Convention were the Honorable Walter Judd, M.D., Representative from Minnesota, Senator John Tower of Texas, James Murphy, M.D., President of the American Academy of General Practice, and Edward Annis, M.D., speaking for the American Medical Political Action Committee, and Ivan Nestingen, Under Secretary of the Department of Health, Education and Welfare.

The House of Delegates went on record as opposing the King-Anderson Bill for medical care under Social Security and reaffirmed their support of the Kerr-Mills program which is now law.

A resolution was passed urging that the American Medical Association resolve the problem of stipends for interns and residents by deciding that "a living wage" should constitute an additional requirement for an "AMA approved internship or residency."

SAMA voted to join the International Federation of Medical Student Associations. IFMSA is an organization of medical student associations from 28 countries. It is primarily interested in the exchange of medical students for short periods of study.

The new national president of SAMA is Jim Brooks of the University of Oregon. The new regional vice president is Ron Naille of Ohio State University.

The financial assistance given by the Kentucky State Medical Association in sending the delegates to the Convention was appreciated.

Terry L. Davis
Delegate from U. of L. Chapter SAMA
Stephen A. Blackman
Alternate Delegate

University of Kentucky
Report on Convention

Joe Christian and myself were privileged to attend the National SAMA Convention in Washington, D. C. last month. We heard many resolutions proposed, some of which were adopted. Among the more controversial issues were resolutions dealing with the King-Anderson Bill and government scholarships to medical students.

Debate raged furious over these issues and it became quite clear that thinking was muddled on both sides. It's invigorating to see people excited, when it's more usual to see them complacent, but it is also irking to see people get red faced over issues on which they do not have the faintest hint of the basic problem. They seemed to be blowing their horns for the noise they made. It reminded me of the two men who were arguing over the size of the iceberg when they could only see the surface.

It seems to me that there are people on both sides who feel more than they think. This is the real danger to medical practice today. If the medical profession is to influence public opinion and instigate wise medical policy, feeling must be guided by reasoning. This places a great responsibility on those in the medical profession to be informed of the facts. We might remind ourselves that the boy who gets the apple may not be the straightest shot, he may just have the most stones.

Ballard Wright
SAMA President
University of Kentucky

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Diabetes Group Incorporated

The Kentucky Diabetes Association has been incorporated and was accepted for affiliation with the American Diabetes Association at the meeting of the Council in Detroit.

Robert S. Tillett, M.D., Louisville, was elected president of the Kentucky Association; Franklin B. Moosnick, M.D., Lexington, vice-president; Arthur T. Hurst, M.D., Louisville, secretary, and William C. Buschemeyer, M.D., Louisville, treasurer. Applications for membership may be had by writing Doctor Hurst at the Medical Arts Building, 1169 Eastern Parkway, Louisville 18, Ky.

Ky. Pediatric Society Elects

Noble T. MacFarlane, Jr., M.D., Lexington, is the new president of the Kentucky Pediatric Society elected at the annual meeting at Frankfort April 19. He succeeds Murvel C. Blair, M.D., Frankfort.

The National Intern Matching Program completed another successful matching operation March 12, 1962. This was the 11th. A total of 6,748 students were matched with 214 going unmatched and seeking internships at the unfilled hospitals. As in the past, nearly as many internships went unfilled as filled. The hospitals offered 12,705 internship posts of which 5,957 went unfilled.

June is National Dairy Month

All KSMA members are urged to observe Dairy Month during the month of June, by Gaithel L. Simpson, M.D., KSMA president, who said, "KSMA is happy to cooperate with the American Dairy Association of Kentucky and recognizes the value of milk as the cornerstone of the American diet."

Dairy Month officially opened in Kentucky with a luncheon in Frankfort and a milking contest between Governor Bert Combs and Commissioner of Agriculture Emerson Beauchamp. KSMA is one of 21 groups cooperating in observing the month.

The American College of Chest Physicians has established a fund to provide loans to resident physicians to stimulate interest in postgraduate study of chest diseases and to assist postgraduate students in continuing studies in diseases of the chest, including heart and lungs. Application forms may be secured from: Committee on Resident Loan Fund, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Thomas Kirby, M.D., formerly of Central City, who has been taking residency training in internal medicine at the Cleveland, Ohio, Hospital Clinic, plans to return to Kentucky in July and join the Graves-Gilbert Clinic at Bowling Green. Doctor Kirby was graduated from the University of Louisville in 1954.

Pertinent Paragraphs

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YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No, 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

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News Items

Emily R. Hess, M.D., has opened an office at the Harlan Memorial Hospital, Harlan, Ky., for the practice of physical medicine and rehabilitation. She is practicing in association with the Miners Memorial Hospital Association. Doctor Hess was graduated from the University of Cincinnati School of Medicine in 1943. She previously was at Ft. Thomas from 1944 to 1950 and again from 1955 to 1958 and most recently was with the Rancho Los Amigos Hospital at Downey, California.

John Hogan, M.D., has started general practice at Campbellsville, Ky. Doctor Hogan was graduated in 1914 from the Chicago College of Medicine and Surgery. He previously practiced at Kaukauna, Wis., for 12 years; was with the Burlington Railroad for 12 years, and practiced on the Menomee Indian Reservation for two years.

Thomas J. Penn, M.D., has begun the practice of general surgery at Somerset, in association with Robert B. Jasper, M.D. Doctor Penn was graduated from the University of Louisville School of Medicine in 1946. He served as a captain in the Marine Corps in 1951-52 and was in practice at Grundy, Va., and Nicholasville, Ky., before going to Somerset.

The 1962 annual meeting and scientific sessions of the American Heart Association will be held October 26-30 at Cleveland, Ohio. Abstracts of papers based on original investigations in the cardiovascular field may be submitted until May 15 on official forms obtained from Richard E. Hurley, M.D., 44 East 23rd St., New York.

Robert C. Burkhart, M.D., who formerly practiced at Harlan, Ky., has opened an office for general practice at Lexington, Ky. He was graduated from the University of Louisville School of Medicine in 1958 and served his internship at Louisville General Hospital. Doctor Burkhart served two years in the U. S. Air Force.

Robert L. Woodard, Jr., M.D., Louisville, has been named chairman of the medical and scientific committee of the Kentucky Chapter, Arthritis and Rheumatism Foundation.

More than 30 Owensboro physicians joined the Owensboro-Daviess County Chamber of Commerce during the April membership drive, according to **James E. Hix, M.D.,** chairman of the medical division of the Chamber's drive. Physicians currently represent 8% of the total membership.

E. Coleman Whitaker, M.D., surgeon, for the past five years at Berea, Ky., has accepted a position with the Veterans Administration Hospital at Johnson City, Tenn., and has moved to that city. Doctor Whitaker, who was graduated from the University of Louisville School of Medicine in 1943, was previously with the VA Hospital at Lake City, Fla. He was serving as president of the Madison County Medical Society.

"Some of the suggestions (for 'regulating' the prescription drug industry) could lead to such legislative strait jackets that the practicing physician would have no flexibility for individual judgment for his patients. More and more, medicine seems to be becoming a challenge to decide what not to do rather than what to do. If the trend continues the average doctor may worry more about how to extricate himself from a case with minimum personal risk than how to treat the sick person for maximum patient benefit."—Austin Smith, M.D., president, Pharmaceutical Manufacturers Association, to State Officers' Conference, American Academy of General Practice.

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Pertinent Paragraphs

The eighth annual meeting of the American Rhinologic Society will be held at the Statler Hilton Hotel, Los Angeles, November 1-2, 1962. The meeting will be preceded by a three-day course in "Expanded Surgery of the Nasal Septum at Loma Linda University, in cooperation with the Society. For further information, write the Society at 530 Hawthorne Place, Chicago 13.

Two courses in rhinology will be presented at the Leiden University, Holland, in July 1963: The first a "Boerhaave" course July 4-6, followed by the fifth international course in "Reconstructive Surgery of the Nasal Septum and External Pyramid" July 7-19 in cooperation with the American Rhinologic Society. For further information write the Society at 530 Hawthorne Place, Chicago 13.

The ninth annual meeting of the Academy of Psychosomatic Medicine will be held at the Radisson Hotel, Minneapolis, November 1-3, 1962. Pre-registration and hotel reservation forms may be obtained from Bertram B. Moss, M.D., executive secretary, 55 E. Washington St., Chicago 2.

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its next meeting April 17-20, 1963, at the Greenbrier Hotel, White Sulphur Springs, W. Va.

The Department of Otolaryngology of the University of Illinois College of Medicine will conduct a postgraduate course in laryngology and bronchoesophagology from September 24 to October 6, 1962, under the direction of Paul H. Holinger, M.D. Registration will be limited to 15 physicians. For more information write: Department of Otolaryngology, U. of I. College of Medicine, 1853 W. Polk St., Chicago 12.

John H. Githens, M.D., Lexington, chairman of the Department of Pediatrics at the University of Kentucky Medical School, on April 18 received an unrestricted grant of $5,000 for medical research from Wyeth Laboratories, Philadelphia. The award is one of 20 made annually by the Wyeth firm to further medical research by medical schools and hospitals.

Donald Chatham, M.D., Shelbyville, president of Georgetown College alumni, aided in the establishment of a Georgetonian Club by the 550 Georgetown alumni in the Louisville area May 16.

Thomas F. Burke, M. D., has resigned as clinical director at Kentucky State Hospital, Danville, and joined the staff of Northeast Florida State Hospital.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #98—A 25-year-old white primigravida was admitted to the hospital on February 14, 1960, with a history of profuse vaginal bleeding. She had not been seen previously by a physician.

Severe Bleeding

The severe bleeding had begun at 5 a.m. on the day of admission, but minor bleeding associated with abdominal cramping pain had been present for three or four days.

The patient's last menstrual period had begun "some time in December" and she had missed a period in January. Subsequent physical findings threw reasonable doubt on the accuracy of this menstrual history. The patient denied any attempt at abortion.

Examination revealed a markedly obese young woman who was bleeding vaginally. On abdominal examination, the fundus seemed palpable midway between the symphysis and the umbilicus. Pelvic examination showed the vagina to be filled with dark blood clots. The cervix was between two and two and one-half fingers dilated, with a mass of tissue protruding from the cervical os; there was considerable active bleeding from the uterus.

The temperature on admission was 100.3° F. and subsequently rose to 102.8°F. The blood count on admission was as follows: RBC, 1,830,000; hematocrit 29.6, WBC, 71,000; neutrophils 68; stabs 48; segmented formes, 29; lymphocytes, 3. She was transfused with 1,000 cc. whole blood.

Dilatation and Curettage

Dilatation and curettage were performed. The mass of tissue protruding from the cervical os was removed with ovum forceps and dull curettage of the endometrium was done, followed by gentle sharp curettage. A two-inch gauze pack was inserted into the uterine cavity.

The cervix showed a vertical laceration extending into the cul-de-sac. The uterus was enlarged to the size of a four or five-months' pregnancy. All the tissue obtained was foul smelling. The pathological diagnosis was placental tissue with inflammation.

Septic Fluctuations

During the ensuing four days, the patient showed septic fluctuations in the temperature curve, together with persistent anemia and leukocytosis with marked shift to the left. Bacillus fusiformis was cultured from the cervical material obtained on admission, but not subsequently.

In spite of transfusions, 3000 cc. whole blood, antibiotics, oxygen, progesterone, ergotrate, sedatives and ataraxics, the patient's condition deteriorated progressively and death occurred on February 21, 1960. The cause of death was recorded on the certificate as "septicemia from fusiform bacillus."

Comments

The committee voted this a direct obstetrical death. The traumatically lacerated cervix was suggestive of criminal abortion. The packing of the uterus in the presence of known infection was considered to be a preventable aggravating circumstance in the clinical management.

The true incidence of death resulting from induced criminal abortion is unknown because of the frequent impossibility of obtaining an accurate history. Statistics published in recent years have suggested that the number of fatal criminal abortions may be decreasing, possibly because of the availability of effective antimicrobial drugs.

The present case may serve as a reminder that despite "wonder drugs," overwhelming infection may still pose a serious threat to life in patients who seek criminal abortion.



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new physiotonic

NOW—the **highest** anabolic plus the **lowest** androgenic activity* with well-tolerated WINSTROL therapy

...for elderly patients with anorexia, asthenia and general debility—
MARKED IMPROVEMENT IN APPETITE, STRENGTH AND SENSE OF WELL-BEING

Fourteen patients, age 66 to 77, treated with Winstrol, usually in a dosage of 6 mg. daily, for various periods in order to correct underweight, weakness and chronic fatigue. Marked improvement occurred in appetite, sense of well-being and strength; almost all patients gained weight.

...for patients with osteoporosis and arthritis—
RELIEF OF PAIN, IMPROVEMENT IN MOBILITY

Twenty-one patients with arthritis treated with Winstrol for pain and limited mobility due to osteoporosis. With few exceptions, dosage was 6 mg. daily; duration of treatment varied from a few weeks to 6 months. In 8 patients relief of symptoms was excellent and in 6 moderate. Of the 7 persons in whom no relief was obtained, 5 had received treatment for less than one month and some had been given doses below 6 mg.

...for patients with malignant disease—
NOTABLE WEIGHT GAINS, INCREASED APPETITE AND SENSE OF WELL-BEING

Twenty-six patients, mostly women, weak, emaciated and seriously ill, were administered Winstrol in dosage of 6 mg. daily for periods extending up to 14 months (average 6.7 months). Notable weight gains occurred. Patients showed increased appetite, alertness and confidence, better appearance, increased mobility and tolerance to pain.

...for patients with chronic, non-malignant disorders—
IMPROVEMENT IN WEIGHT AND GENERAL ACTIVITY, INCREASED SENSE OF WELL-BEING

Eight patients with advanced tuberculosis, bronchopulmonary disease, nephritis and ulcerative colitis treated with 6 mg. of Winstrol daily for from 3 to 4 months. Gains in weight varied from 6 to 27 pounds with increased sense of well-being and improvement in general activity.

...for undernourished, underweight children and adolescents—
NOTABLE IMPROVEMENT IN APPETITE AND OUTLOOK, MARKED INCREASE IN WEIGHT AND HEIGHT

One hundred and twenty children, age 1 to 11 years, underweight and in poor health, were given Winstrol for several months. Majority received daily dosage of from 2 to 4 mg. In nearly all, appetite was improved. Over 70 per cent showed significant gains in weight of from 5 to 17 pounds.

DOSAGE: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

*animal data

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patients look better...feel stronger—because they are stronger

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PUBLIC HEALTH PAGE

Labeling Requirements For Prescription Drugs

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health*

Commonwealth of Kentucky

THE passage of the Food, Drug and Cosmetic Act by the Kentucky General Assembly in 1960 brought Kentucky's law up to date and in conformity with federal law. In some instances, the Kentucky Food, Drug and Cosmetic Act makes it mandatory for us to follow federal law and to accept standards and regulations promulgated by the federal government.

One field where this is particularly true is that of new drugs and drugs requiring a prescription, since the State is not financially capable nor equipped to evaluate the numerous drugs being distributed and offered for sale on the market today.

This recent explosion of new drug products poses many problems even at the federal level and has caused many revisions to be made in the existing regulations.

One set of regulations that is of particular concern to physicians and pharmacists is that of labeling of prescription drugs. These regulations will probably result in the most sweeping change in the labeling and promotional literature supplied to physicians for potent pharmaceuticals since the passage of the Federal Food, Drug and Cosmetic Act in 1938.

Quite often, before these regulations were adopted, the material designed to inform the physician about a new drug never came to his attention. If this information was available, it was so seldom requested in some cases, it was not necessary for a pharmaceutical firm to have to print the material for distribution.

As a result of representations made by detail men, mailing pieces and other promotional efforts, some physicians felt it unnecessary to seek further information. Of course, these sources *are* necessary but few if any of them provide all the information essential for the safe use of the drugs.

The first step taken by the Food and Drug Administration in 1956 was to require that the final printed labeling be submitted before the new drug application was approved. This at least made sure that the printed information was available and more likely to be distributed. However, further improvement of drug information was needed.

It was felt that not only the proposed advantages and uses of a drug be given but also the full story of its uses as well as its side effects and needed precautions. Only in this way can a physician have a proper basis to judge which drug he should prescribe for his patient.

The second problem was to make this information readily available. With this in mind, in July 1960 regulations were proposed which would revise the label requirements for prescription drugs. These regulations were issued in December 1960 to become effective in September 1961.

Briefly, these changes provide that any labeling for prescription drugs and devices—labeling to include promotional literature mailed or detailed to physicians or practitioners—that furnishes or purports to funish knowledge for use of such a dosage, must contain the full information about the drug, including relevant hazards, contraindications and precautions, etc.

In the case of new drugs this labeling must be substantially the same as authorized in the new drug application. The labeling is required to bear the date of issuance of the new drug application or its latest revision so that the reader will have an indication as to how current the information presented on the labeling is.

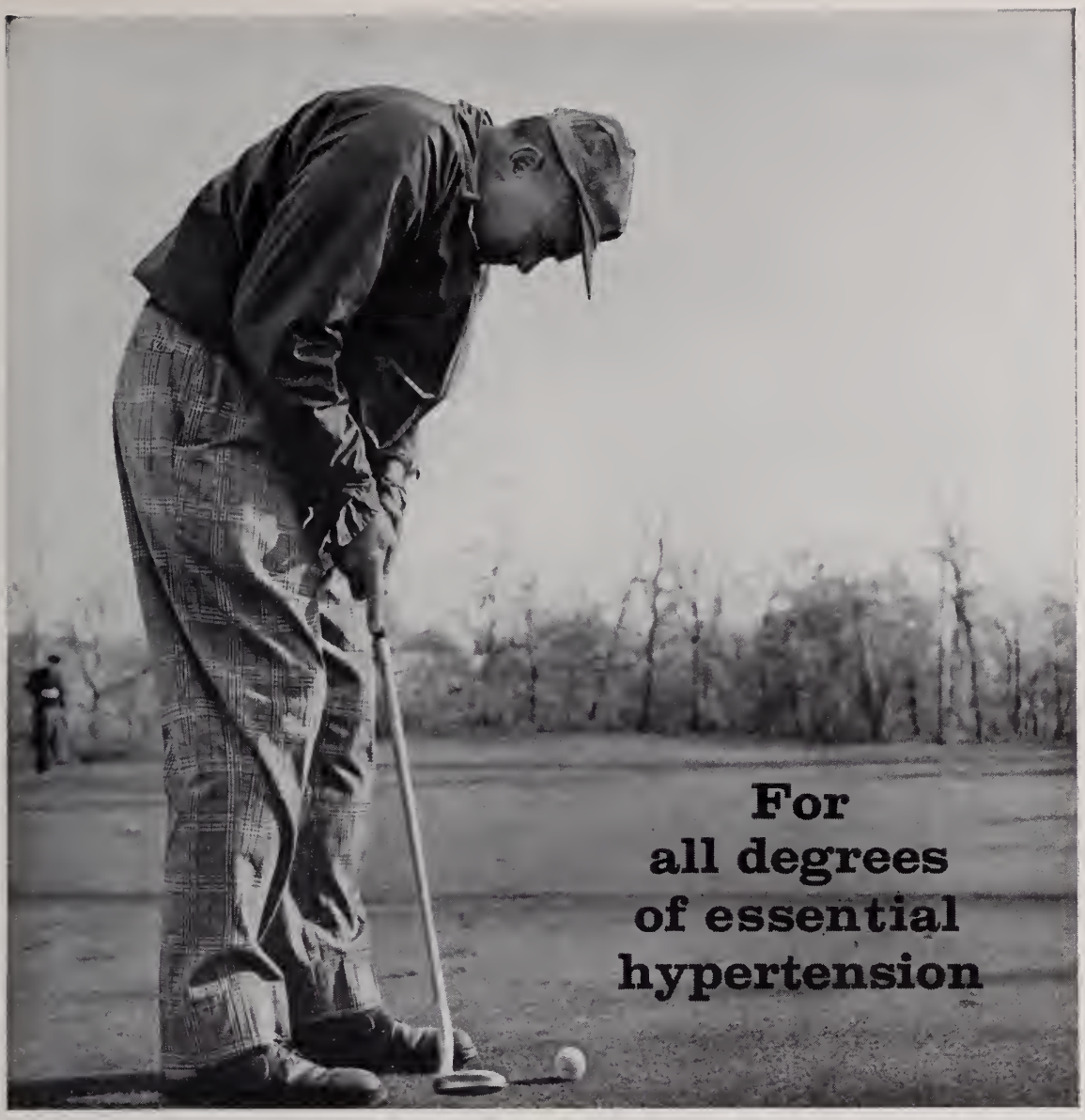
Labels for all prescription drugs must declare the quantity or proportions of each active ingredient. Drugs for parenteral injection and for ophthalmic use in addition must declare the quantity of all inactive ingredients.

Labels for prescription drugs must bear identifying lots or control numbers from which it would be possible to determine its manufacturing history. The labeling regulations also require that most prescription drugs bear full informative labeling to accompany each market package.

These changes are aimed at providing necessary information to the prescribing physician for safe and effective use of the drug. It will also place the pharmacist in a better position to render a professional service in the distribution of prescription drugs.

Even in this way, the final target is still not achieved since the market package with the full information will still usually remain in the possession of the pharmacist. However, the information is at least available. If the drug can be supplied to the patient,

(Continued on page 610)



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

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IN THE BOOKS



AN ATLAS OF HEAD AND NECK SURGERY: by J. M. Lore, Jr.; published by W. B. Saunders Company, Philadelphia and London; 490 pages; price, $25.

The author of this book has been trained both in general and in head and neck surgery and as such approached his subject with an unique breadth of surgical approach. The wide scope of the subject matter reflects the author's remarkable interest and abilities.

Few surgeons will be equally at home or comfortable taking care of all of the operative problems illustrated in this book for it includes removing pituitary tumors, reshaping cleft lips, performing patch grafts on the carotid arteries, and draining empyemas.

The author's thesis is that a well-trained head and neck surgeon should be able to handle all problems in this anatomic area and take care of complications arising therefrom. Only neurosurgery and ophthalmology are excluded. Discussions and illustrations of superior mediastinal node dissection for certain carcinomas of the thyroid make one think the title might be "Surgery of the Head and Neck and Anatomic Structures Attached Thereto."

In actuality there is, in my opinion, good reason for including such sections as how to treat cardiac arrest, or to take a bone graft from the ileum, although some, I am certain, will object to the catholic approach to this surgical specialty.

The choice of subject matter is extensive and I find no fault with his selections. The next edition, I think, should include techniques of perfusion or infusion of head and neck tumors and a section in closed chest cardiac massage. This is not a criticism for obviously these minor and very recent advances cannot be included in a monumental work of this type.

The material of this atlas naturally must be compared with the book of Hays Martin who wrote an interesting non-committal prolegomenon. Lore's book tells his story much in pictures and includes more plastic and non-tumor surgery than does Martin's.

Any surgical atlas stands or falls on the drawings. Robert Wabnitz is director of medical illustration at the University of Rochester Medical Center and has done an excellent job both in technical drawing and in selecting key stages of an operation for illustration in this book. His pictures are on occasion diagramatic or fully shaded and detailed as the occasion demands. Happily they are not overcrowded with labels and lines which have been almost an irresistible temptation to illustrators of head and neck atlases since the Middle Ages.

The book is well bound and printed; has a good index and a general bibliography. It will be invaluable to the general surgeon or surgical resident who operates about the head and neck. The plastic surgeon and the otolaryngologist who specialize in this field will probably be more than familiar with much of the contents but they will undoubtedly benefit from reading and referring to a book with such a broad approach to their specialty.

Ben Eiseman, M.D.

GENERAL PATHOLOGY: edited by Sir Howard Florey; published by W. B. Saunders Company, Philadelphia and London; 1104 pages; price, $22.

This book, now in its third edition, is comprised of a series of lectures delivered to medical students at Oxford University. The title is misleading. The term, 'general pathology,' has a particularly unpleasant connotation. To the graduate physician it brings to mnd the old second year course in medical school, where, as Doctor Florey points out, "the teaching of pathology is centered on the post-mortem room and the museum."

Perhaps a better title would be "General Pathology, The New Look." Instead of emphasizing altered morphology, disordered function is stressed.

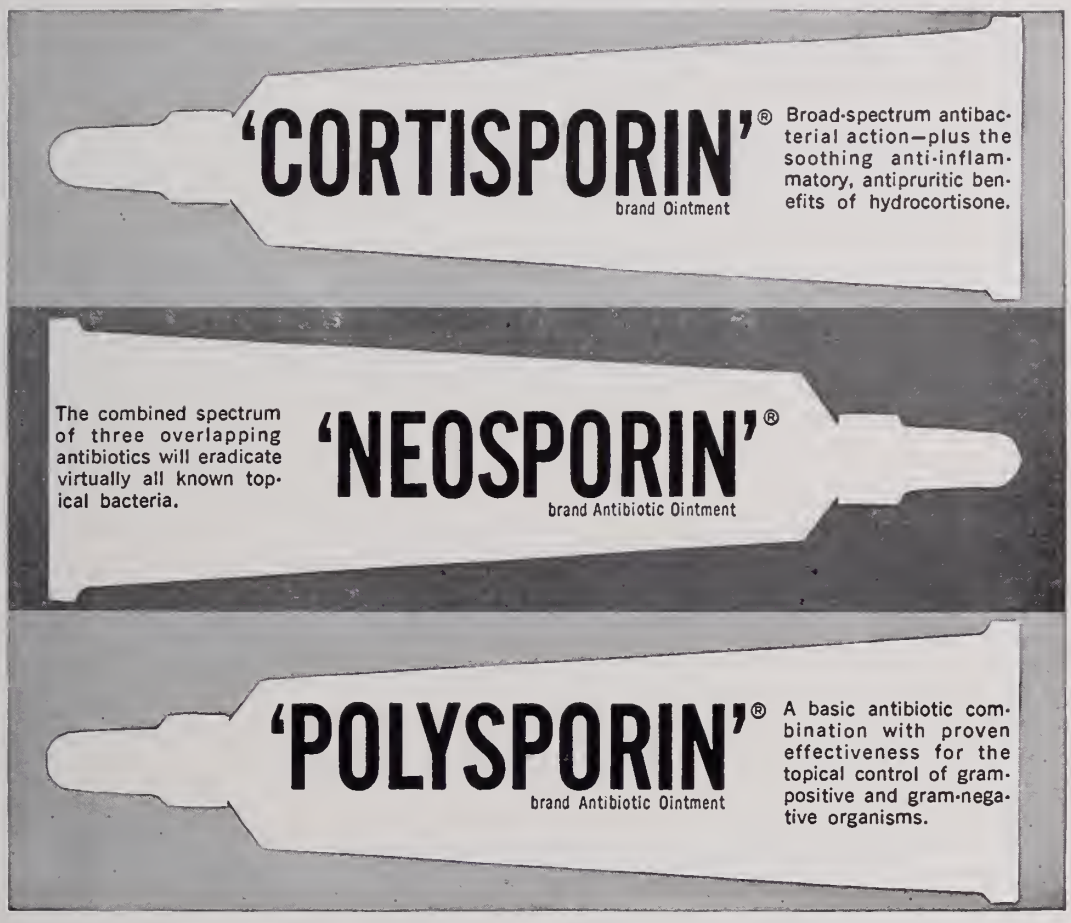
The series of lectures is not comprehensive; it is not intended to be so. It augments but does not replace the standard textbooks of pathology. Nevertheless, many of the basic problems of medicine are included. There are chapters on immunology, neoplasia, infections, coagulation defects and thrombosis. The more recent contributions to an understanding of these problems are well discussed.

The several lectures (or chapters) devoted to immunology are excellent. Beginning with the concept of antigen and antibody, there follow discussions of immunity, anaphylaxis, allergic disorders and tissue transplantation. The entire subject is presented in logical sequence, though each lecture can be read as a separate unit.

For the student who is interested in supplementing his knowledge of general patho-physiologic principles, this book is highly recommended. It also merits reading by the postgraduate physician who wants to keep up-to-date with basic medicine.

G. Randolph Schrodt, M.D.

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Answers To Questions About Your BLUE SHIELD

Q. Why can't commercial insurance companies provide a prepayment mechanism instead of Blue Shield?

A. Commercial insurance companies could provide a mechanism if they would do the following, at community rates:

1. Permit continuation of protection regardless of age or health.
2. Permit continuation of protection when a member retires or leaves the group.
3. Permit dependents of deceased members to continue protection.
4. Permit children reaching age 19 or marrying before 19 to continue protection in their own name, regardless of physical condition.
5. Reduce their overhead operation and cost to that of Blue Shield.

Economic control of medicine would be lost by medicine, however, should Blue Shield be taken out of the picture and all prepayment be provided by insurance companies, since the profession would have no voice in their policy or operation.

Q. Is Blue Shield a cooperative?

A. No. Blue Shield is a corporation operating under the laws of Kentucky on a not-for-profit basis. The Board of Trustees is composed of 75% doctors and 25% laymen, who serve without pay as a community service. Any funds received in excess of cost of care and overhead operations are held in reserve for care of members. A cooperative is defined as a business enterprise or society whose object is to enable its participants to buy or sell to better advantage by eliminating middlemen's profits.

Q. Is the Blue Shield concept in keeping with the American idea of the free enterprise system?

A. Yes. It is a business corporation, administered by doctors and civic-minded businessmen. It was organized by the State Medical Association to fill a community need: To help people budget in an economical way in advance to meet their responsibility for the cost of specific surgical and medical services.



Welcome to another year of Lederle Symposia

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 11th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 55,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife for whom a special program is planned.

SPOKANE, WASHINGTON
Saturday, June 2, 1962
The Davenport Hotel

BIRMINGHAM, ALABAMA
Saturday, June 2, 1962
Dinkler-Tutwiler Hotel

WASHINGTON, D. C.
Saturday, June 9, 1962
Marriott Motor Hotel

LAND O'LAKES, WISCONSIN
Sunday, June 17, 1962
King's Gateway Hotel and Inn

EAU CLAIRE, WISCONSIN
Wednesday, June 20, 1962
The Eau Claire Hotel

ATLANTA, GEORGIA
Wednesday, July 18, 1962
The Hotel Dinkler Plaza

SAN ANTONIO, TEXAS
Sunday, September 9, 1962
The Granada Hotel

CLARKSBURG, WEST VIRGINIA
Sunday, September 9, 1962
The Stonewall-Jackson Hotel

TYLER, TEXAS
Wednesday, September 12, 1962
Carlton Hotel

KANSAS CITY, KANSAS
Friday, September 14, 1962
Battenfeld Auditorium

WOODSTOCK, VERMONT
Wednesday, September 19, 1962
The Woodstock Inn

NIAGARA FALLS, ONTARIO
Saturday, September 29, 1962
Sheraton-Brock Hotel

RAPID CITY, SOUTH DAKOTA
Saturday, October 6, 1962
Holiday Inn

FINDLAY, OHIO
Thursday, October 11, 1962
The Findlay Country Club

HONOLULU, HAWAII
Sunday, October 21, 1962
The Princess Kaiulani Hotel

NEWARK, NEW JERSEY
Sunday, October 28, 1962
Robert Treat Hotel

SANTA BARBARA, CALIFORNIA
Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
Wednesday, November 7, 1962
Marott Hotel

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

In Memoriam

JACOB JOSEPH GLABOFF
Louisville
1904-1962

Jacob Joseph Glaboff, M.D., 57, Louisville, died May 16 at St. Joseph Infirmary after a long illness. He was a pediatrician in Louisville for 30 years and at the time of his death was an associate professor of pediatrics at the University of Louisville School of Medicine.

Doctor Glaboff was graduated from the Vanderbilt University School of Medicine in 1927. He was a past president of both the Louisville Pediatric Society and the Kentucky Pediatric Society and on the staff of St. Joseph Infirmary and General Hospital.

SAMUEL ERNEST PARIS, M.D.
Bowling Green
1903-1962

Samuel Ernest Paris, M.D., 58, Bowling Green, Ky., eye, ear and nose specialist, was killed in a private plane crash May 10. The plane crashed shortly after take-off from the Anton Airport in Hopkins County. Three other Bowling Green men were killed in the accident.

Doctor Paris was the pilot and owner of the plane. The four had been to Madisonville, Ky., to attend a meeting of the Rizpah Shrine. Doctor Paris was grand senior warden of the Masonic Grand Lodge of Kentucky and in line to become grand master, the lodge's highest position, in October 1963. He was graduated from the University of Louisville School of Medicine in 1933.

Public Health Page

(Cont. from page 604)

the necessary information can be supplied the physician by the pharmacist.

The requirement for control numbers or lot numbers being a part of the drug label should prove very helpful not only to the manufacturer in his control operations, and to regulatory officers checking on certain portions of drug products, but it should also prove useful to all who must handle drugs throughout the complex distribution patterns in today's merchandising mechanism. Certainly in the event of a drug recalled for any reason this information is a most useful factor and would help facilitate the task of everyone concerned.

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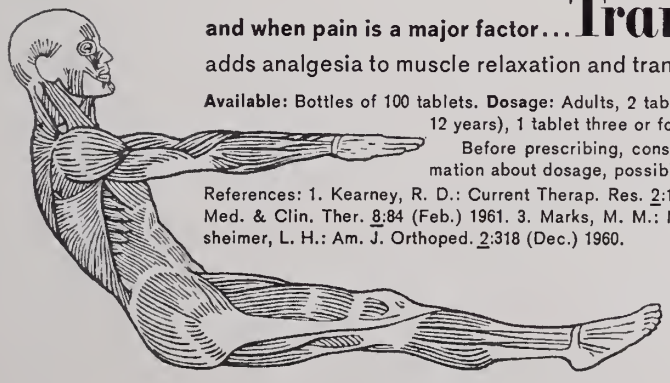
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References: 1. Kearney, R. D.: Current Therap. Res. 2:127 (April) 1960. 2. Cornbleet, T.: Antibiotic Med. & Clin. Ther. 8:84 (Feb.) 1961. 3. Marks, M. M.: Missouri Med. 58:1037 (Oct.) 1961. 4. Hergesheimer, L. H.: Am. J. Orthoped. 2:318 (Dec.) 1960.

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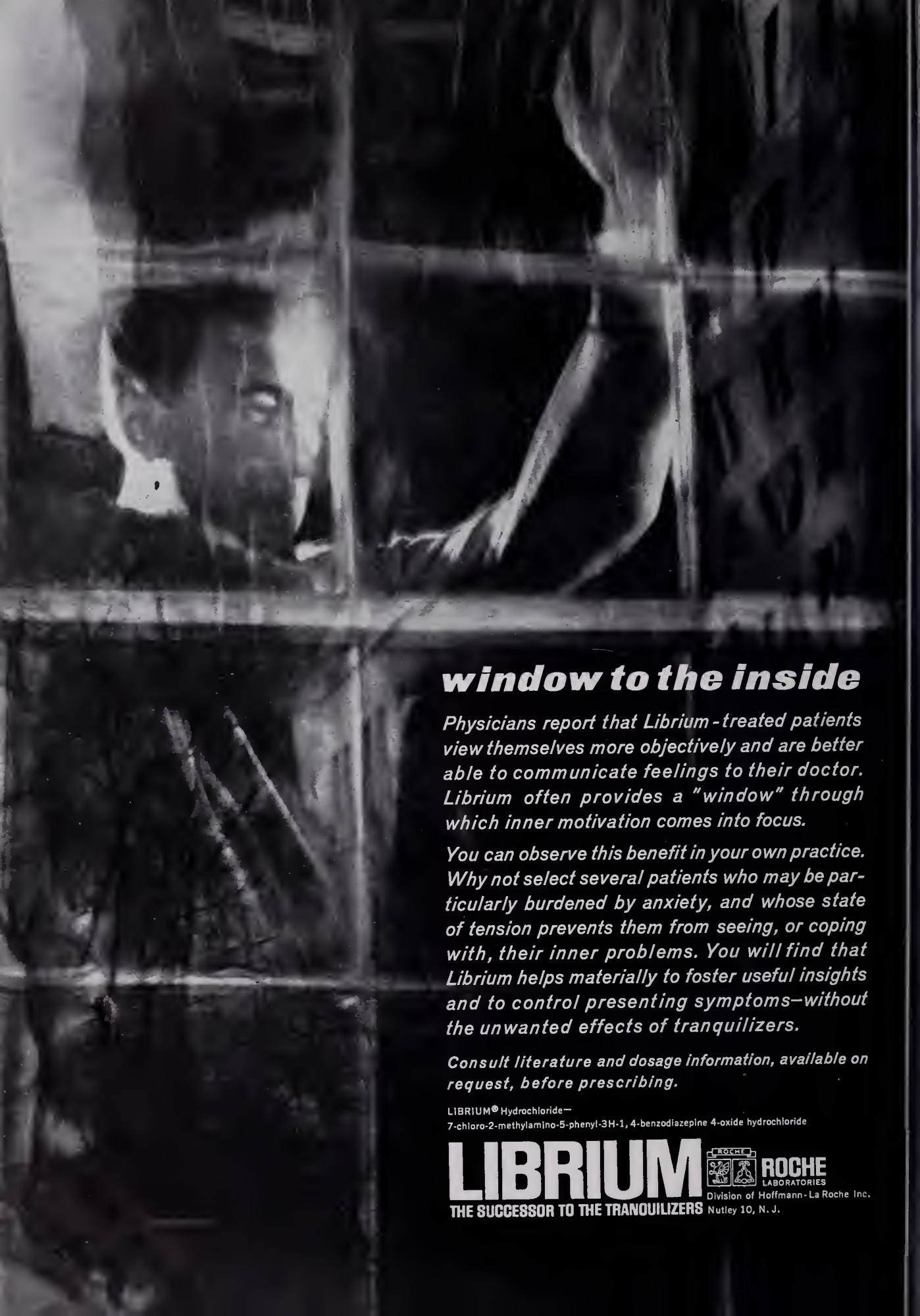
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The incidence of postoperative wound infections, particularly among debilitated patients, presents a serious hospital problem.[1] These infections are caused in many cases by strains of staphylococci resistant to most antibiotics in common use.[1,2,3] In such instances, CHLOROMYCETIN should be considered, since "...the very great majority of the so-called resistant staphylococci are susceptible to its action."[4]

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References: (1) Minchew, B. H., & Cluff, L. E.: *J. Chron. Dis.* **13**:354, 1961. (2) Wallmark, G., & Finland, M.: *Am. J. M. Sc.* **242**:279, 1961. (3) Wallmark, G., & Finland, M.: *J.A.M.A.* **175**:886, 1961. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Hodgman, J. E.: *Pediat. Clin. North America* **8**:1027, 1961. (6) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. (7) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (8) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959.

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MESSAGE FROM THE PRESIDENT

Let's Be Politicians*

THE past six months have introduced many physicians to the somewhat foreign field of politics. Our recent and continued fight against government control of certain phases of medical practice has sharpened our interests. Fresh approaches and activities in the form of AMPAC and KEMPAC, have begun. A new concept about doctors in politics is evolving. This is a necessity if we are to be represented and preserve our free practice of medicine.

The word "politics" should no longer make us feel uncomfortable; it should not conjecture a picture of smoke filled rooms and underhanded or unprofessional activities. With the evolution of our present system of government and society we must be politicians or be drowned in an ocean of frustrations, controls and materialistic Socialism.

Politics is an honest mechanism of a free enterprise system by which we can obtain direct action to see to it that our ideas are promoted, that our liberties are preserved; not legislated away.

If we sincerely believe in our present free enterprise system of medicine and society in general, we must do the following things:

1. *BE INFORMED.* We can no longer be casually acquainted with the problems that have confronted medicine and business and government. As educated individuals, it is our duty to be aware of every local, state, or national policy that would jeopardize our free enterprise system. We must be as concerned with the farmer's problems, the pharmaceutical industries problems, big-business problems, labor problems, as we are with our own.

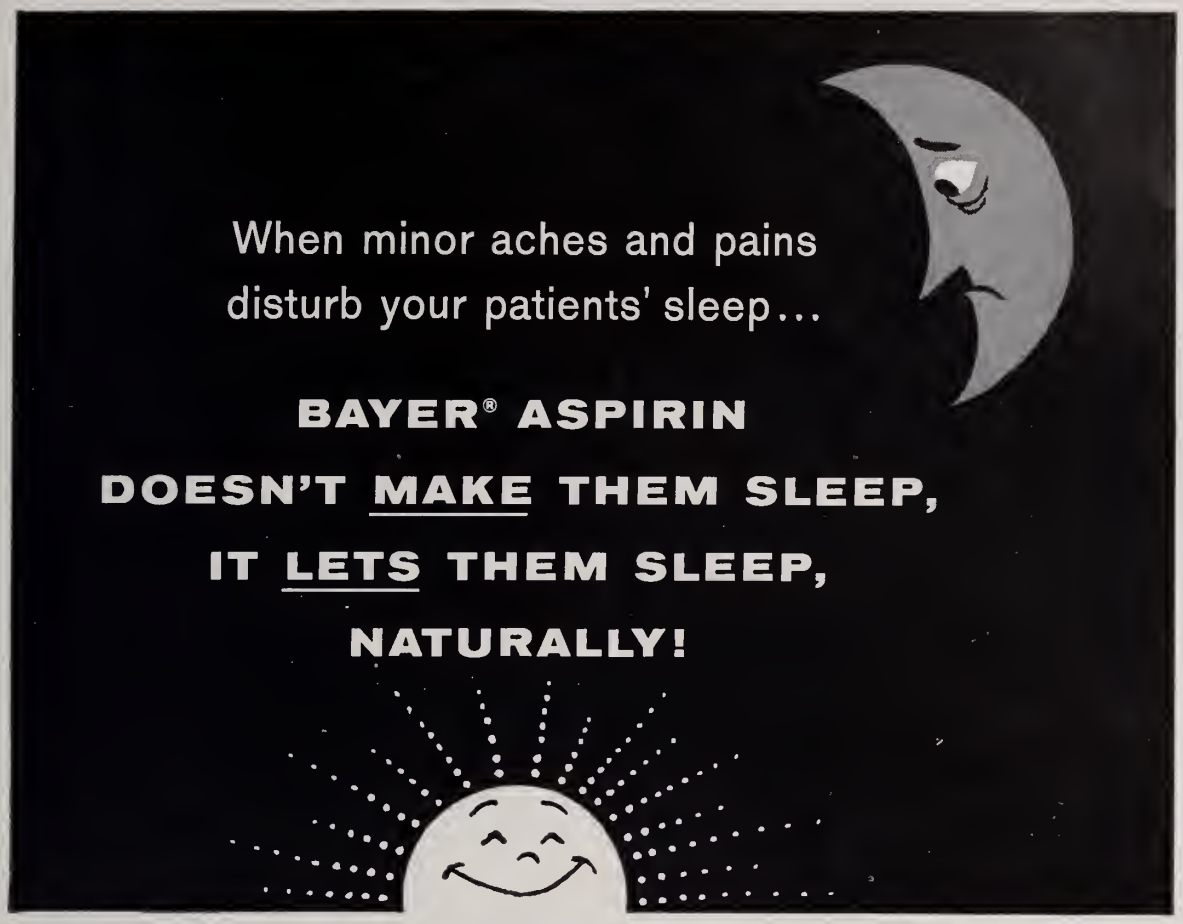
2. *BE CONSISTENT.* If we believe in this system of free enterprise we must be consistent in our application of its principals. We cannot be selfish and think only of the government's effect upon medicine but we must develop the philosophy that our grandfathers possessed; that America represents freedom and real democracy. We must oppose with all of our vigor any encroachment upon this system whether it be continued government control of farmers, or the swallowing up of private power companies by continued expansion of T.V.A.

3. *PARTICIPATE.* Never has there been a greater opportunity for the individual physician to participate in these activities. We must participate not only in terms of financial contributions, but with ideas. Each of us may not agree as to the methods of solution of problems that face us, and this is as it should be. We must participate more strongly in our local county societies as well as our K.S.M.A. and A.M.A., so that all ideas may be presented and considered. We must participate in our local communities seeing to it that candidates worthy of holding public office are nominated and supported. We must be proud of our A.M.A. Lobby in Washington, and our organizations of KEMPAC and AMPAC, since they represent a necessary approach in helping to foster our beliefs and retain our freedoms.

Many have felt it is too late; that Socialism is inevitable; that there is nothing that we can do. I firmly believe that this is not true! If we are informed, if we are consistent and if we participate, we physicians, a small segment of our wonderful democracy, can preserve and strengthen our free enterprise system and feel happy with the heritage that we pass on to our children.

WALTER R. JOHNSON, M.D.
KSMA Vice President (Western)

**This is the third of the guest pages written by each of the three KSMA vice presidents at the request of Gaithel L. Simpson, M.D., KSMA president.*



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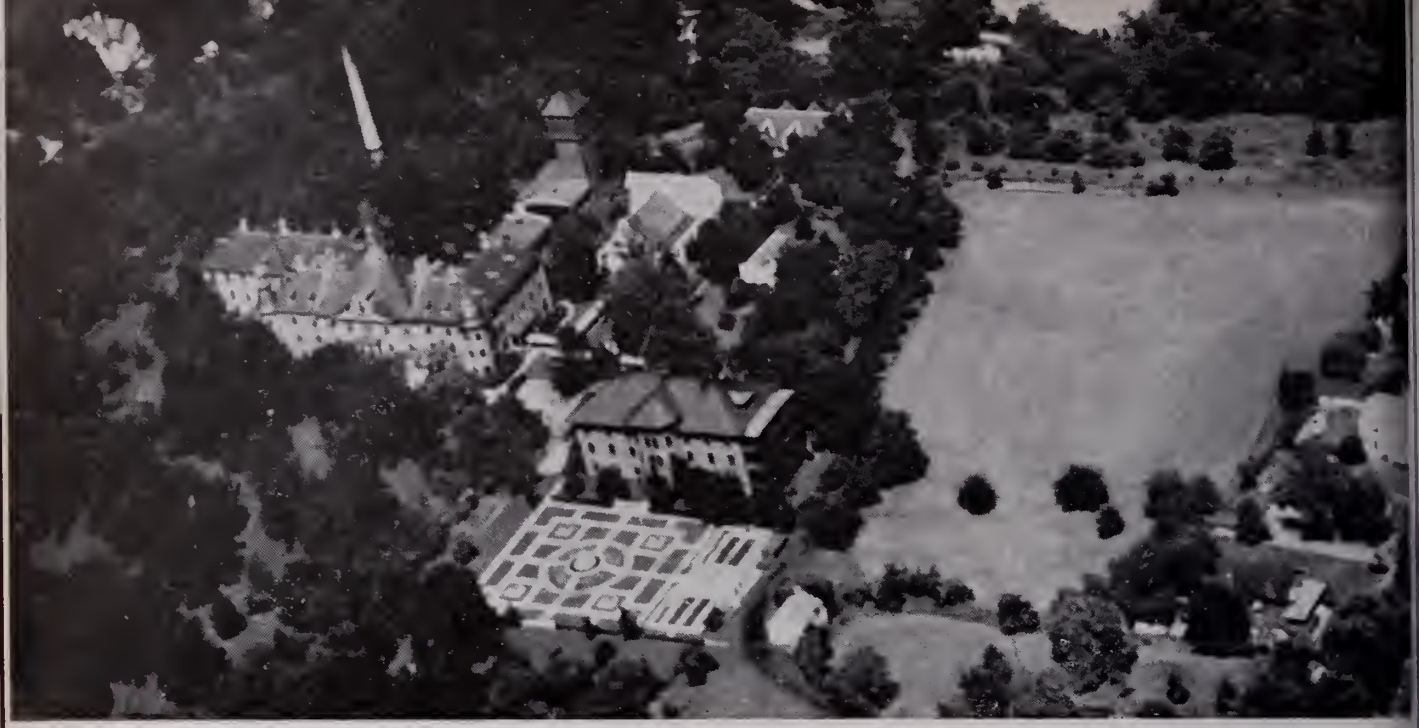
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The Other Side Of The Coin

AS OLD as the Oath of Hippocrates is the concept that physicians may not reveal to others the secrets of the patients. Small wonder, then, that as physicians, we are reluctant to allow any third party to have access to the clinical records of our patients.

At the same time, we must recognize that the patient has a complete right to make available to others any information concerning his illness, especially when the information is needed in order to protect his interests.

Let us look at the other side of the coin, also. What about the rights of the health care prepayment organizations—the Blue plans, and the insurance companies?

An Economic Principle

The solvency of any voluntary prepayment plan depends upon the simple economic principle that income (receipts from premium payments) may not be less than outgo (money paid out in benefits plus operating costs). One need not be an insurance expert to recognize that any company which would pay every claim made against it, without investigating the legitimacy of the claim, soon would either be operating in the red, or else would be forced to increase its premium rates; thus making the honest contract holders underwrite the fraudulent claims of a dishonest minority.

It thus becomes apparent that every insurance company and prepayment plan not only has the right, but indeed, has an absolute obligation to make sure that each claim qualifies for payment according to the terms under which the contract was written. One of the functions of the state insurance department is to see that this policy is enforced. Most contracts contain a clause by which the insured agrees that he will furnish the prepayment plan or insurance company with all necessary information concerning an illness for which a claim is made.

An Established Fact

Our courts have established the fact that a patient has a vested interest in his hospital records, and that he may authorize a third party to obtain information from these records. The exact manner in which the hospital shall release this information may vary according to hospital regulations; but the legal right of a hospital or physician to withhold any pertinent part of a patient's clinical record from an insurance company, which has received proper authorization from the patient, has not been established.

In all fairness, one must acknowledge that without such safeguards, insurance companies and prepayment plans could be, and in all probability would be subjected to intolerable abuses; and that the very survival of the voluntary prepayment mechanism would be threatened.

W. Vinson Pierce, M.D.

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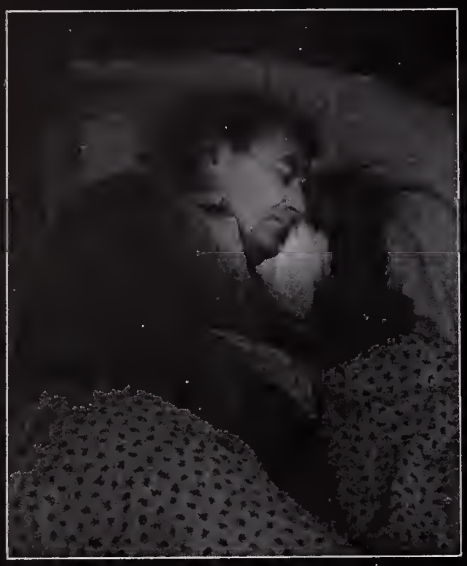
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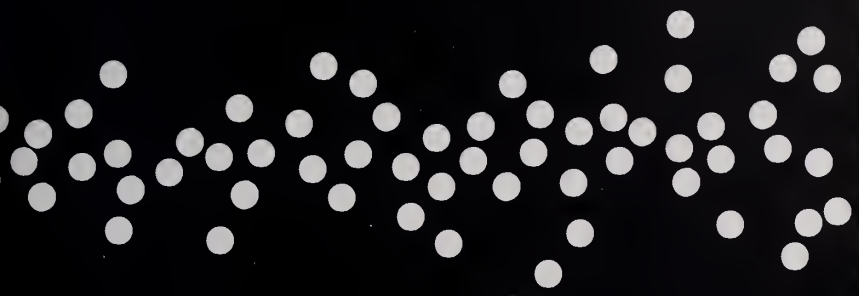
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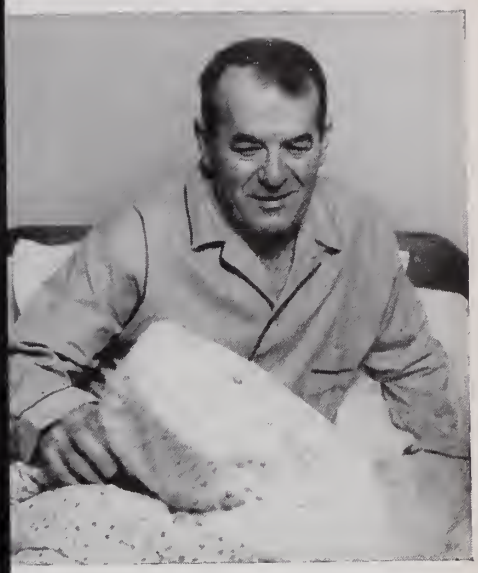


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3	P SC	= =	= =	++++ +
4	P SC	= =	= =	++++ +
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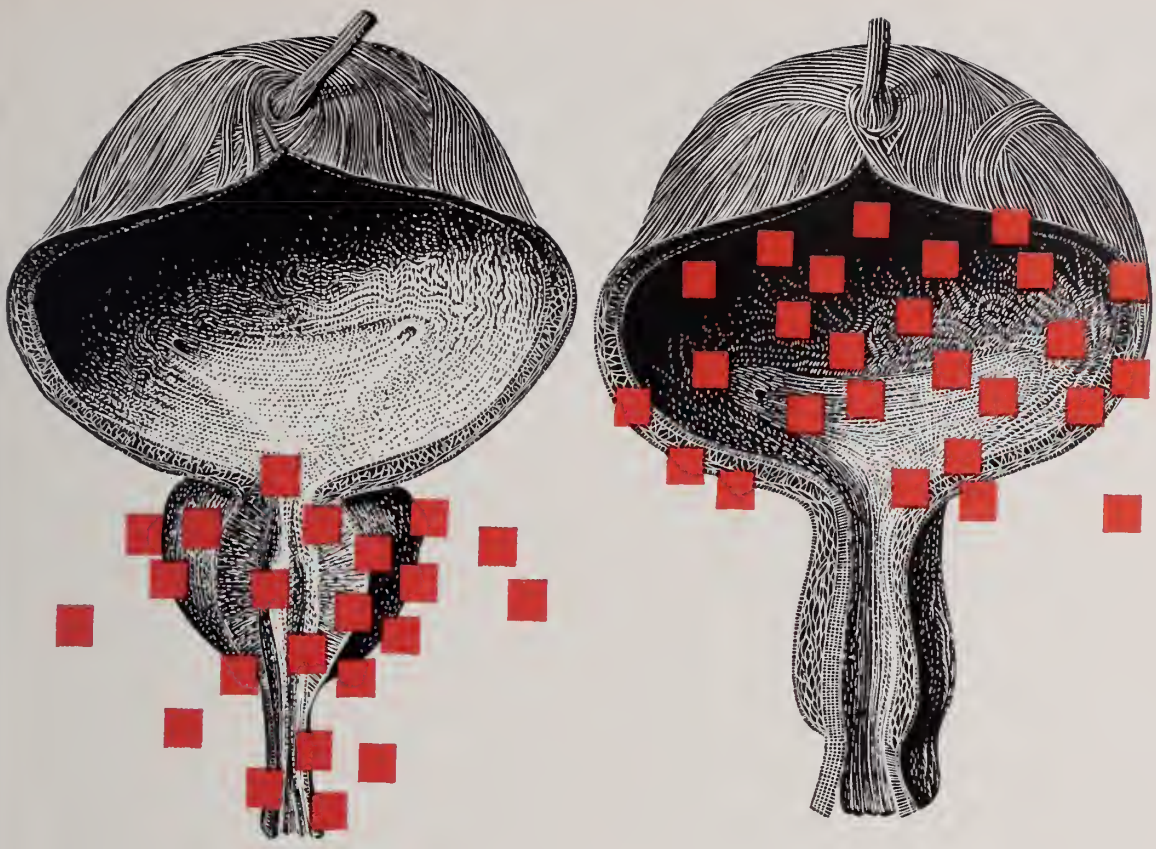


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WASHINGTON NEWS DIGEST



WASHINGTON, D.C.—The American Medical Association challenged the Kennedy Administration on the accuracy and legality of its propaganda campaign for the King-Anderson Bill.

F. J. L. Blasingame, M.D., executive vice president of the AMA, wired Attorney General Robert Kennedy about a booklet issued by the Department of Health, Education and Welfare. Doctor Blasingame said:

"This booklet lobbies for the enactment of the King-Anderson Bill. This bill would raise Social Security taxes to provide limited health services to aged beneficiaries, regardless of whether they need financial help.

"The Department of Health, Education and Welfare has used tax funds, collected from everyone, to propagandize for a bill which many people and many groups have vigorously opposed. Under law, the publishing of this kind of a booklet without Congressional authority is a criminal act, punishable by fine or imprisonment, or both, and removal from office."

AMA President Leonard W. Larson, M.D., wrote President Kennedy correcting a misstatement the Chief Executive made at a news conference.

The President told his news conference that "the AMA was one of the chief opponents of the Social Security system in the '30's."

Doctor Larson pointed out to Mr. Kennedy that the AMA had never opposed the Social Security system, either before or after its adoption.

"The Association," Doctor Larson's letter said, "testified before Congress on only one section of the Social Security legislation, the section concerning extension of public health services. It should be noted that the AMA testified in support of this section."

Doctor Blasingame also called on the Justice Department to stop Cabinet members from using taxpayers' money for lobbying purposes and to launch an investigation of "improper" lobbying activities of employees of the Department of HEW.

Doctor Blasingame, in a letter to Attorney General Robert Kennedy, listed more than a dozen incidents which he said violated federal statutes prohibiting lobbying by federal employees and officials.

"Government employees," Doctor Blasingame said, "are being sent out as speakers at public meetings to urge enactment of the Administration's bill. This, in our opinion, is a clear violation of Title 18, Section 1913 of the U. S. Code on crimes and criminal procedure which prohibits among other things the use of 'personal services' for lobbying purposes."

Doctor Blasingame said that Secretary of Commerce Luther Hodges, Secretary of Labor Arthur Goldberg and Interior Secretary Stewart Udall were appearing at rallies concurrent with President Kennedy's appearance in Madison Square Garden in the Administration's campaign for the King-Anderson Bill.

"We strongly protest the use of tax monies by these Cabinet members to lobby for a bill which is clearly not within the scope of their respective departments," Doctor Blasingame said. "I call on you to issue an injunction against this type of activity by these Cabinet members."

The AMA Executive Vice-President also noted that between six and ten government employees "have been lobbying in the White House offices for several months" for the King-Anderson Bill. He said the group occupying a four-room suite "has been writing television and radioscripts, drafting advertisements and helping with publicity releases for various organizations which are backing the King-Anderson Bill."

Doctor Larson also urged that "the American people demand an honest accounting from the Department of Health, Education and Welfare on how much of their tax money the Department is spending on lobbying for the King-Anderson Bill."

"The people have a right to know how much of their tax money this federal agency is spending in lobbying for this piece of legislation," Doctor Larson said in a speech before the Academy of Medicine of Cincinnati.

Doctor Larson said also that the National Council of Senior Citizens should be required to register as a lobbyist.

"This organization was founded by former Congressman Aime Forand for the express purpose of lobbying for passage of the King-Anderson Bill," Doctor Larson said.

In a statement, Doctor Larson cited contradictory statements by two prominent advocates of President Kennedy's h e a l t h-care-for-the-aged-bill—Secretary Abraham Ribicoff and Rep. Cecil R. King (D., Calif.).

"Mr. Ribicoff and Mr. King may be on the same team but they are in basic disagreement as to the extent of services Social Security should provide and how much of an increase in taxes the public will tolerate to finance these services," Doctor Larson said.

Doctor Larson said "This is what is happening: Secretary Ribicoff, in an effort to make the King-Anderson Bill palatable to those fearing greater federal taxes, is saying that the health care program will not be expanded because Social Security taxes have just about hit 10%—his estimate of the saturation point.

"Meanwhile, Mr. King, in order to gain the support of those who believe in the 'federal government playing the role of Santa Claus' is promising increased Social Security benefits in the future."

(Continued on Page 705)



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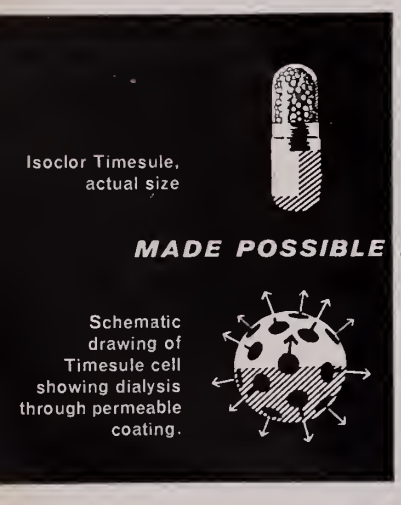
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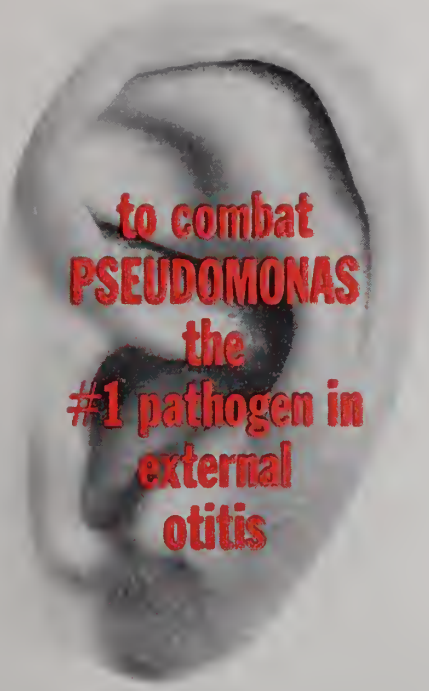
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In a special form providing prolonged therapeutic effect.

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—Gray, H. R., Wolf, R. L., and Doneff, R. H.: Evaluation of Flurandrenolone, a New Topical Corticosteroid, Arch. Dermat., *84:*18, 1961.

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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 60 JULY, 1962 NO. 7

Favus in Kentucky: Diagnosis, Treatment and Epidemiology*

A. B. LOVEMAN, M.D., AND EMIL KOTCHER, SC. D.**
Louisville, Ky.

Twenty-five cases of favus have been located in Eastern Kentucky and treated with griseofulvin. To date, all have been cured. The clinical diagnosis, historical aspects, epidemiology, and mycological findings are discussed in detail.

FAVUS is a chronic fungus infection of the scalp, occasionally involving the nails and glabrous skin, and due usually to *Trichophyton schoenleini.* It is characterized by yellowish, cup-like crusts or scutula, a mousy odor, and usually terminates in alopecia and atrophic scarring.

Though reliable statistics are lacking, the incidence of favus in the United States, and in probably most of the world, has been in decline. Despite the general economic and public health improvements in the United States, we still have endemic foci of such infections as favus, trachoma and helminthiasis, in regions where poverty, ignorance and a lack of sanitation and personal hygiene exist. Even with therapy capable of effecting dramatic cures, the persistence of such infections may continue for many years because of a complex of social and economic factors.

Prior to the discovery of griseofulvin, a *Penicillium*-produced antibiotic, as an effective agent against the dermatophytes, there had not been an adequate, readily available treatment for favus. Griseofulvin has been used effectively abroad[6, 7, 8, 9, 10, 15, 16, 17, 27, 29] in the treatment of favus, but only one case so treated has been found in the American literature.[24] Occasional mention of cases treated with griseofulvin have been reported by Goldman[14] in papers dealing in a general way with the drug or in discussing griseofulvin in the treatment of tinea capitis. Mitchell[16] was the first to employ this drug in the treatment of favus.

The purpose of the present study was to locate cases of favus, diagnose, treat and study the epidemiology of the cases found, and if possible eradicate the infection from the Commonwealth of Kentucky.

Materials and Methods

Clinical Methods: Patients suspected of favus were examined directly in the local health department, in our office (A. B. L.), and in the home of the patient. The scalp, face, torso, arms, feet and nails were examined for lesions suggestive of those described for favus. The

*Presented at the General Scientific Session of the Kentucky State Medical Association Annual Meeting in September 1961 at Louisville, Ky.

**Department of Medicine, Section of Dermatology and Syphilology and Department of Microbiology, School of Medicine, University of Louisville, Louisville, Ky.

Schering Corporation, Bloomfield, N. J., furnished the drug (griseofulvin) and in addition gave generous financial assistance.

EDITOR'S NOTE: The length of this article far exceeds that set up as Journal policy. However, due to unusual circumstances, it has been decided to carry it in one issue.

patients were viewed both in the daylight and in the dark with Wood's light (nickel oxide filter glass) in order to observe fluorescence. Fluorescent hairs were plucked and put into a paper envelope and identified with the individual's name, address and the date. Toenail specimens also were collected. The weight, age, and general health of the patient was noted, as well as the scalp and skin conditions. The scalp was examined carefully to detect any "mousy" odor characteristic of certain cases of favus.

Mycologic Methods: Examination of Hairs: A 15% solution of potassium hydroxide was used to examine fluorescent hairs for the presence of infection with dermatophytes. By this method, it was possible to determine whether the fungus grew in the cortex of the hair shaft (endothrix) or on the surface of the hair shaft (ectothrix).

Culture of Hairs: Fluorescent hairs were collected for cultivation on media suitable for dermatophytes. At first, Sabouraud's dextrose agar, to which penicillin, streptomycin and cycloheximide had been added, was used. Subsequently, Bacto-Mycobiotic agar which contained cycloheximide and chloramphemicol was employed. After primary isolation of the dermatophytes, the Bacto-Trichophyton agars No. 1, No. 2, No. 3, and No. 4 containing inositol and thiamine, alone and together, in a vitamin free casamino acid medium were used to identify the organism culturally. All cultures were incubated at room temperature in screw-cap tubes. The cultures were examined grossly and microscopically at varying intervals of time for nature and rapidity of growth and pigmentation of medium and mycelium. Microscopic preparations of the mycelium were made with lacto-phenol cotton blue and examined for the presence and nature of conidia as well as the structure of the hyphae (favic chandeliers).

Culture of House Dust: House dust from two homes in which favus cases lived was collected in vacuum cleaners. The dust was mixed with sterile saline and inoculated on (a) Sabouraud's dextrose agar to which penicillin, streptomycin and cycloheximide had been added, and on (b) normal hair. The material was incubated at room temperature. Mycelium from colonies was examined microscopically for presence of characteristic dermatophyte conidia and hyphae.

Treatment Regime: The patients were given griseofulvin in tablets of 250 mg. or 500 mg. size and instructed to take them for 12 weeks. The following treatment regimen was prescribed:

Under 50 lbs.—250 to 500 mg. daily (250 mg. b.i.d.)

50 to 100 lbs.—750 mg. daily (250 mg. t.i.d.)

Over 100 lbs. or adult—1 gm. daily (250 mg. q.i.d. or 500 mg. b.i.d.)

The patients were re-examined usually at the end of a month, although in some instances a greater period of time elapsed between examinations. They were questioned relative to any cutaneous, gastrointestinal or neurological disorders they may have experienced during treatment.

Patients were also strongly advised to crop or shave the scalp at the end of the third or fourth week after commencing therapy. Frequent shampoos with green soap and the topical application of a weak fungicidal preparation were advised in order to remove crusts and debris. The criteria of cure in these patients were:

1. No evidence of clinical activity.
2. Two negative examinations for fluorescence at one month interval.
3. Two negative mycological cultures at one month interval.

Diagnosis

Clinical: Favus may be suspected clinically, but the final diagnosis rests with the laboratory. Many of these cases, particularly the chronic ones with extensive involvement, were so classic in appearance that the diagnosis could be made readily. Yet there were early cases that not only defied recognition but favus would not have been considered as a diagnostic possibility had there not been other typical cases in the same family, or had our clinical suspicion for recognition not been raised because we were studying this problem.

The division of these cases into "Early" and "Late" is entirely arbitrary. Undoubtedly, there is an overlapping, in that similar findings of an early case with either minimal or extensive involvement may occasionally occur in some late cases. In general, however, the infection in most of the early cases is less than two years old, whereas the late cases represent older infections. The following clinical types were noted in this study of 25 cases.

1. Early Cases:

a. Minimal Involvement: Such cases often showed isolated, dry, follicular scaling areas indistinguishable from a patch of seborrheic dermatitis, psoriasis or atopic eczema. (Fig. 9). In the very early cases, no scarring or alopecia was noted, although there could be seen some slight thinning of the hair in the involved areas.

b. Extensive Involvement: These cases showed palm-sized areas of diffuse seborrheic type of scaling in which there was usually moderate thinning of the hair (Plate I, Fig. 1). Another type of involvement was the psoriatic type, with the scaling more silvery in color, resembling psoriasis or eczema more than seborrheic dermatitis (Plate I, Fig. 5). This may or may not be associated with mild alopecia. A rare observation noted with the above types was one or two isolated scutula unaccompanied by scarring but occasionally accompanied by mild alopecia (Plate I, Fig. 2).

2. Late Extensive Involvement: Four types of cases were observed in which the infection was extensive and of long duration.

a. Diffuse, Door-Mat Type: Among the first few cases seen were those with a severe exudative type of involvement associated with diffuse, crusty type of scaling, a "mousy" odor, marked inflammation, follicular pustules and moderate alopecia and scarring (Plate I, Fig. 3, 6).

b. Diffuse, Extensive Scutula: This is a typical, easily diagnosed type although rarely observed. The scalp looks like a mass of dry, yellowish-white crusts, which are both discrete and confluent and are frequently pierced by hairs. The discrete, inverted, cup-like or saucer appearance characteristic of typical scutula is quite evident. There is an associated marked inflammatory process, folliculitis, and extensive scarring (Plate I, Fig. 7; Fig. 12).

c. Localized Alopecia with Atrophic Scarring: This type has single or multiple areas of alopecia and atrophic scarring. They may vary from 2 cm. in diameter to areas of palm size or even larger. There may not be any inflammatory process present, or mild erythema may be noted in the periphery of the areas involved. It is in such cases that fluorescent hairs can be detected under the Wood's filter. The rest of the hair is usually normal and luxuriant (Fig. 13). Fluorescence is of particular value in this type of case and it was observed in all cases with active infection.

d. Diffuse Alopecia with Seborrheic Scaling: In these cases the hair is diffusely thinned, may or may not have a "mousy" odor, and the infection is still quite active as is evidenced by areas of moderate inflammation and a seborrheic type of scaling (Fig. 10).

Results

Clinical Appraisal: The 25 paticnts fell into three groups as a result of familial and geographical associations. These groups were appraised from the standpoint of:

1. Rapidity of clinical remission.
2. Relapses, reinfection or resistant infections.
3. Number of cures.

1. Rapidity of clinical remission: Of the 12 cases from Magoffin and Johnson Counties, two showed clinical activity, although greatly reduced, two months after starting therapy. One patient, although he showed no clinical activity at the end of two months, showed some activity at five months. The other nine patients showed no activity at the end of the second month following the initiation of the treatment. None of these 12 patients showed signs of clinical activity nine months after starting therapy.

Three of the 10 patients from Laurel County showed some clinical activity, though markedly reduced, one month after starting therapy. They were not examined the second month, but all 10 were completely negative for clinical activity at the end of the third month and again at six months. Several were examined again at eight months and were still negative for any evidence of the disease.

Only one of the three patients from Laurel County showed activity at the end of the first month following treatment. This was a case of rather extensive scutulae throughout the scalp (Plate I, Fig. 7, Fig. 12). All three patients were negative clinically at the end of two months and four months after initiating therapy.

All 25 cases were clinically cured at the end of eight months. With the exception of one resistant case, none showed clinical evidence of the disease at the end of three months. The majority were negative at the end of two months, and many at the end of one month.

2. Relapses, reinfections or resistant infections: Four children from Magoffin County had been diagnosed and started treatment in the Children's Hospital in Louisville. After a

CHART I.

Clinical and Mycological Activity of Four Typical Cases

	R. F. H.				P. R.					L. B.				R. V.			
Date	CA.	Fl.	Mi.	Cu.	CA.	Fl.	Mi.	Cu.	Date	CA.	Fl.	Mi.	Cu.	CA.	Fl.	Mi.	Cu.
9/60	+	+	+	+	+	+	+	+	5/61	+	+	+	+	+	+	+	+
11/60	—	+	—	—	—	—	+	—	6/61	—	+	+	+	+	+	+	+
2/61	—	—	—	—	+	—	+	—	7/61	—	—	—	—	—	—	—	—
6/61	—	—	—	—	—	—	—	—	8/61	—	—	—	—	—	—	—	—
9/61	—	—	—	—	—	—	—	—	11/61	—	—	—	—	—	—	—	—

CA. = Clinical Activity
Fl. = Fluorescence
Mi. = Microscopic Examination
Cu. = Cultural Examination

hospital stay of one to three weeks, they were discharged with a month's supply of griseofulvin. Three of the patients were clinically negative six weeks after initiating therapy. They were seen again four months after treatment was started and were clinically and culturally negative. However, five months later (nine months after they had been seen initially) three of these four patients had clinically active favus caused by the same species of fungus, i. e. *Trichophyton schoenleini*. The treatment regimen was started again in these three patients, and they were eventually cured.

In one unusual case the patient was cured clinically but found to be positive for *T. Schoenleini* from an infected hair. The patient subsequently relapsed clinically but was ultimately cured.

The clinical and mycological activity of four typical cases is shown in Chart I.

3. Number of Cures: All 25 patients were cured, clinically and mycologically, under the treatment regimen delineated. (Chart II.) Occasional retreatment was necessary when there was renewed clinical activity. The patients were followed from a minimum of four and one-half months to as long as 20 months in some cases. The criteria of cure, i.e. no evidence of clinical activity and two examinations negative for fluorescence and negative for mycological cultures each at one month interval were achieved on each patient.

CHART II.

Results of Therapy

Group	No. Cases	Months Observed	Relapses or Reinfections	Mycological Cures	Clinical Cures
Ia	3	20	2*	3	3
Ib	9	9	0	9	9
II	10	8	0	10	10
III	3	5	0	3	3

*Additional therapy given, ultimately cured.

Mycology: All of the patients revealed dull, greyish or yellow-green fluorescence under the Wood's filter. Either brilliance of the fluorescence varies or else the individual author's interpretations vary. Ferguson[10] describes it as a bright green; Mitchell[16] merely as greenish, and Wereide[27] as a bluish-green. Before treatment,

PLATE I: (Color Plates)

Figure 1—Thinning of hair and diffuse seborrheic type of scaling.

Figure 2—Isolated scutulae, thinning of hair, and seborrheic scaling.

Figure 3—Diffuse extensive door-mat type of involvement with alopecia and atrophic scarring.

Figure 4—Same patient as Figure 3, twenty months post-griseofulvin.

Figure 5—Psoriatic type of scaling.

Figure 6—Diffuse extensive involvement similar to Figure 3.

Figure 7—Extensive scutulae, alopecia, atrophic scarring, before treatment.

Figure 8—Same as Figure 7, four and one half months post-griseofulvin. Note regrowth of hair.

PLATE 1



Figure 1



Figure 2



Figure 3



Figure 4



Figure 5



Figure 6



Figure 7

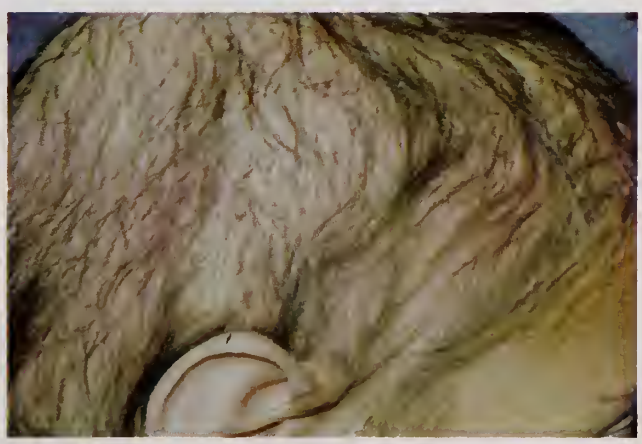


Figure 8

most of the hairs fluoresce throughout their entire length. After a month or so of griseofulvin therapy, only the distal portion of the hair would show evidence of the infection, whereas the proximal portion appeared perfectly normal. In most cases, the fluorescence disappeared by the end of two months but an occasional case persisted the third month, particularly if the patient refused to crop the hair or shave the head.

Examination of the fluorescent hairs in 15% KOH revealed only the endothrix type of infection in all cases (Fig. 14). The infected hairs showed mycelial elements and air-bubbles within the hair shaft and extending to the hair follicles. After treatment for two weeks or more, the hair follicles were free of mycelial elements and a zone of new-growth, uninfected hair was observed. Distal to the hair follicle, the infected, older hair with mycelial elements could be observed. Endothrix type infection was found in 23 of the 25 patients, or 92%. Scutula were examined in 15% potassium hydroxide and a mass of mycelial elements were observed in such preparations.

Cultivation of fluorescent, infected hairs was accomplished best on Mycobiotic agar (Difco). The chloramphenicol and cycloheximide were effective in suppressing the overgrowth of the slow-growing *T. schoenleini* by bacteria, yeasts and non-pathogenic fungi. *Aleurisma carnis,* which was not suppressed by cycloheximide, did overgrow *T. schoenleini* in one patient. After some experience, an identification of a faviform dermatophyte could be made in about 10 days at room temperature on mycobiotic agar (Fig. 15). The fine, white to colorless, mycelial growth shows hyphae with beginning favic chandelier formation. After a couple of weeks of further growth, the colony assumes a whitish to cream color, with white, velvety aerial hyphae. The colony is heaped, wrinkled and rather strongly adherent to the medium. When fragments of the colony are transferred to the trichophyton agars, Nos. 1, 2, 3, 4, growth occurs about equally well in these media, thus establishing the identification as *T. schoenleini.* This organism was successfully cultured and isolated in 19 of the 25 cases, or 76%. In the remaining cases, the diagnosis was confirmed on such criteria as microscopical examination, fluorescence and clinical findings, as well as the presence of favus in other members of the family.



FIGURE 9

Innocent seborrheic type of scaling with scutula-like lesions.

Epidemiology: The population from which these cases came is native-born American of English and Scotch-Irish lineage, descended from early settlers of Kentucky. The majority of the patients are blonde, particularly the children, and fair of skin. The physical stature of the patients was normal, and none were malnourished.

The houses of some of the patients were visited and were found not to have running water or indoor toilets. The sanitation in these homes left much to be desired. Crowding seemed a common factor. All of the cases came from a rural environment. The economic status of these families was low, but none was destitute.

Education did not go beyond the high school level, and the majority of the adults had little or no high school education. Dogs were kept as pets by some families, and pigs and chickens were also present in some yards. While the environment is rural, the families are in frequent communication with other families by virtue of schools, community churches, buses and cars. Some members of the families had moved into Ohio and Illinois.

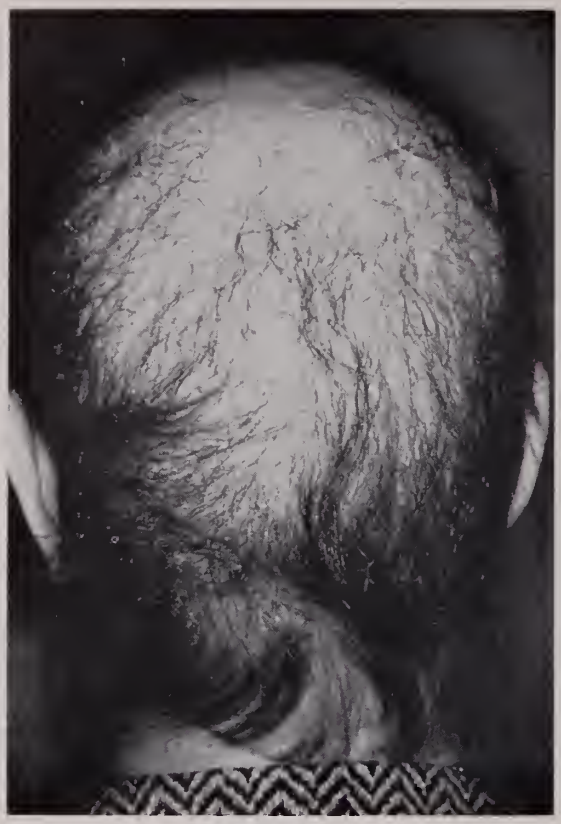


FIGURE 10
Extensive alopecia, scarring and seborrheic scaling of 20 years' duration.



FIGURE 11
Same as Figure 10, eight months post-griseofulvin. Note regrowth of hair.



FIGURE 12
Localized alopecia with atrophic scarring.

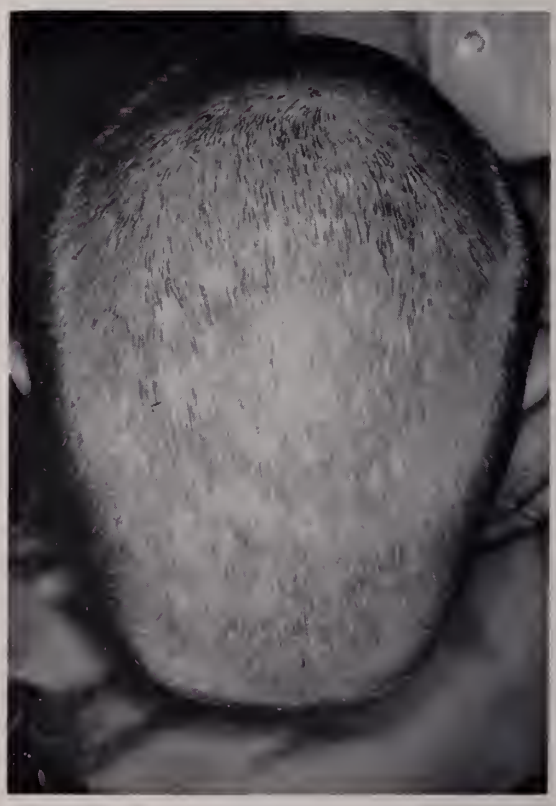


FIGURE 13
Note residual scarring with alopecia.

Familial Relationships of McGoffin-Johnson County Cases

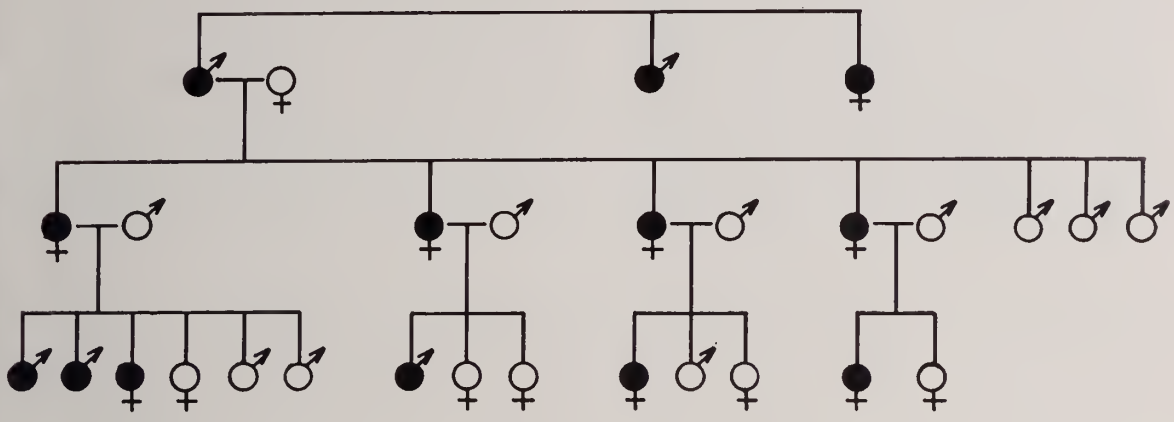


CHART III.

Familial Relationships of Laurel County Cases

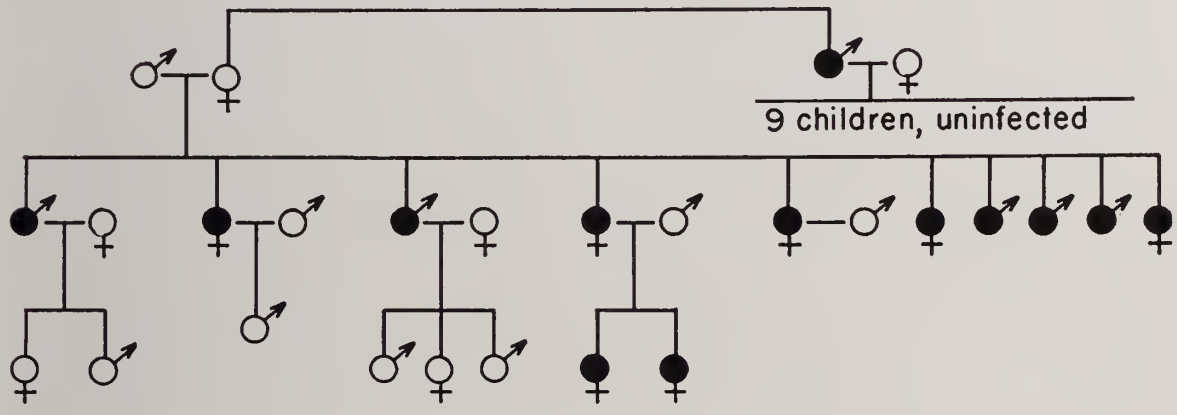


CHART IV.

Dark symbols indicate infected individuals.

Familial relationship in one series of families is shown in Chart III, where the infection was found to occur in three generations.

The youngest patients in this series (Chart III) acquired their infections during the first two years of their life in most instances. These infections were acquired from their mothers, who had active infections as evidenced by scaling and scutula, fluorescent hairs, endothrix type of infections and mycologic cultures positive for *T. schoenleini*. These mothers, who were in their twenties, had had the infection as long as they could remember. Evidence of the chronicity of their infection was the large areas of the scalp bald as a result of the destruction of hair follicles.

Only the peripheral zone of the bald areas had active infection. These four mothers are sisters whose father had had favus since childhood. In addition to their father, an aunt and an uncle were similarly infected. Thus, the infection is known in three generations of these families.



FIGURE 14

Hairs from favus case treated with 15% KOH. Upper hair shows endothrix-type of infection with mycelial elements and air-bubbles. Lower hair is uninfected.

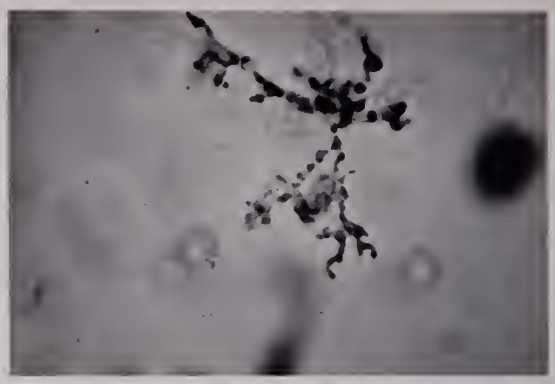


FIGURE 15

Mycelial fragment of TRICHOPHYTON SCHOENLEINI cultured on mycobiotic agar at room temperature for 3 weeks. Note characteristic favic chandelier.

In the Laurel County cases, the oldest individual with evidence of favus was a maternal uncle who had come to live with the family as a young man. His infection was acquired and spread to 10 children in the family. The marital partners of these adults did not acquire the infection. In the majority of instances the infection was acquired either during infancy (under two years of age) or during early childhood. The familial relationship in the Laurel County cases is shown in Chart IV.

Despite the familial incidence of favus, there is much that is unknown concerning its infectiousness and transmission within a family. Both marital partners were never found infected in spite of living together for many years. In one family, one of a pair of twins and a younger brother were infected, but the second twin was not infected in spite of sleeping and playing with his infected brothers.

Cultivation of household dust from two homes in which favus occurred failed to yield colonies of dermatophytes or mycelial structures characteristic of dermatophytes. Microscopic examination of dust suspensions revealed the presence of mites and macroconidia similar to those found in the genus, *Microsporum*. *T. schoenleini* was not cultured from this dust.

Discussion

a. Clinical: On the basis of the results obtained with griseofulvin, it is evident that this is the drug of choice in the treatment of favus. It concentrated in the keratin of the hair and prevents invasion of new hair by the fungus.[22]

With people who live under unhygienic conditions, it is difficult to differentiate relapse from reinfection or even from a resistant type of infection. Three such cases were encountered. Two probably represented reinfection inasmuch as their mother was infected. A brother of these two patients who had been infected and treated with them did not become reinfected.

The third patient who showed renewed clinical activity was a boy who was hospitalized for a time and sent home to continue therapy. He was seen intermittently over the next 18 months, and at times appeared clinically negative, only to be found clinically active some months later, at which time it was necessary to reinstitute therapy. Eventually this patient was cured, both clinically and mycologically, but his case is an example in which it was difficult to determine whether relapse, reinfection, resistance or lack of diligent treatment was the cause of recurring clinical and mycological activity.

Other investigators[13, 17] have reported similar cases. Degos,[6, 7] however, has had no relapses or reinfections, and believes that in favus cases griseofulvin has its greatest success. Petit[17, 18] feels it is "the penicillin of the dermatomycoses."

With proper dosage and supervision, along with occasional retreatment, favus can definitely be cured with griseofulvin. It is believed that the minimum duration of therapy should be eight weeks, although all of our cases were treated for a total of three months. Various authors have given griseofulvin for varying periods of time. Kopp[15] treated his cases 70 to 78 days. Petit[17] believed that four weeks was sufficient, and inadvertently cured one after two weeks of therapy. With rather extensive experi-

ence in using griseofulvin, Degos[6, 7] believed that 21 days was all that was necessary to cure his cases. All of our cases have been followed for a period of not less than four and a half months, and up to as long as 20 months. The last two examinations done a month apart in every patient revealed no clinical activity and were corroborated with negative laboratory findings.

There were no reactions as a result of taking the griseofulvin in the dosage prescribed. Goldblatt,[13] however, has reported the development of a severe angioneurotic oedema in a patient receiving griseofulvin, and one of us (A.B.L.) has seen two cases of urticaria from the use of this drug. One was so severe that it prevented resumption of therapy with griseofulvin.

b. Mycology: Microscopic examination of hairs and the cultivation of *T. schoenleini* did not present any technical difficulties. It is believed, however, that a higher percentage of patients would have been proven culturally positive had it been certain that fluorescent infected hairs were plucked for microscopic and cultural examination in all cases. In the earlier patients, this was not done and consequently in some with classical clinical activity, positive mycological data was not obtained. The importance of being certain of plucking fluorescent infected hairs was appreciated later when positive mycological findings were obtained in all cases.

We found the commercially prepared mycological agar (Bacto-Mycobiotic agar, Difco) more satisfactory than that made in this laboratory for suppressing bacteria and saprophytic fungi. The only fungus encountered and not suppressed was *Aleurisma carnis*. The identification of *T. schoenleini* was based not only on the microscopic morphology of the mycelium (favic chandeliers) and the absence of macronidia, but also on the growth of the organism on the Bacto-Trichophyton agars, Nos. 1, 2, 3, and 4, which contain inositol and thiamine alone and in combination (George and Camp).

The failure to isolate *T. schoenleini* from the house dust of two homes may have been a technical failure rather than an absence of the organism in this material. Antibiotic-incorporated Sabouraud's agar was used in these tests and they became rapidly and heavily overgrown with bacteria and saprophytic fungi.

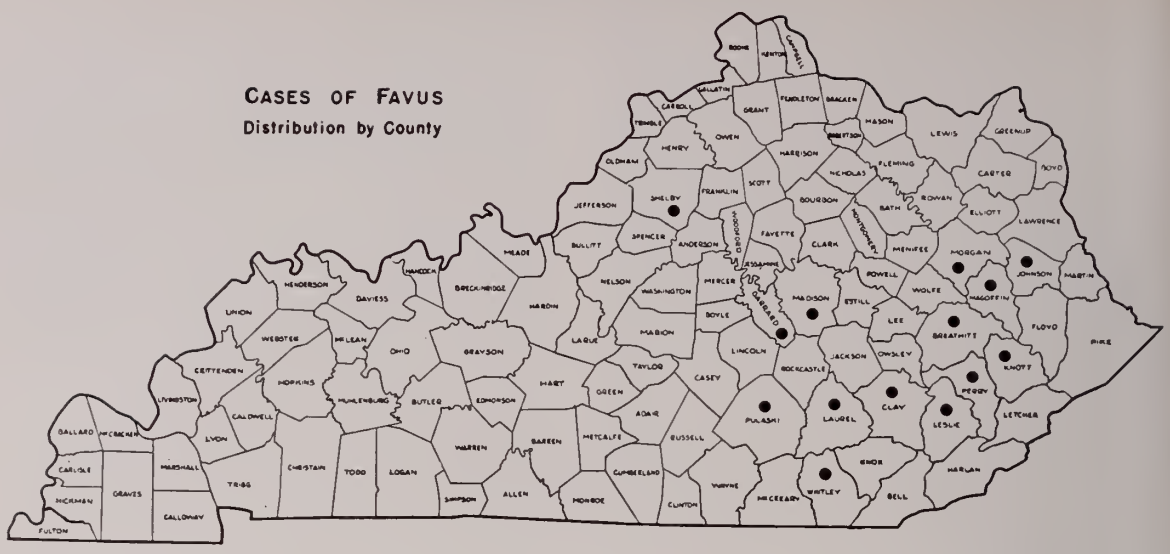
c. Epidemiology: Recent textbooks in dermatology and mycology state that favus is infrequent in the U. S. A. When found, it is chiefly among eastern European immigrants, although native-born Americans have been found with the infection in Kentucky,[1, 2, 23] North Carolina,[21] Georgia,[8] Oklahoma,[25] etc. The infection has been studied extensively by Blank[3] in Quebec among native-born individuals of French lineage. The Public Health Service reports of the late 19th and early 20th century[20] list favus as one of the common diseases among medically examined immigrants entering eastern and western ports. Such favus infected immigrants were also found at ports of embarkation, e.g. Naples, Hong Kong, Shanghai, Kobe and Yokohama. The existence of favus in an immigrant was sufficient cause to advise denial of entry into the U. S.

The current series of cases are native-born Americans of English and Scotch-Irish descent who have lived in relative isolation and have not had contact with eastern European or Asian immigrants as far as it is possible to establish. It is probable that these cases are derived from an earlier wave (late 18th and early 19th century) of favus infected immigrants who did not undergo medical examination at ports of entry. Favus was endemic in England and Scotland according to dermatological treatises of the early 19th century.[4]

Barrett[1, 2] has felt the infection remained endemic among the descendants of these earlier immigrants by virtue of the relative isolation, familial crowding and poor personal and familial hygiene. See the map showing distribution of favus cases reported in the Commonwealth of Kentucky over a period of years.

The occurrence of favus in families has been well documented.[3, 8] Its distribution within a family may seem inconsistent, however, and only indicates how little is known concerning the contagiousness of the fungus and the factors responsible for initiating the infection.

In this study, six marital partners were encountered in which only one of the marital pairs was infected, in spite of the fact that the marriage had existed for years in some instances with ample opportunity for the infection to be acquired. Children of these marriages frequently acquired the infection within the first two years of life. It appears that there is considerable resistance in adults to acquisition of the infection. However, once the infection is



acquired it progresses in the adults as readily as it does in children. No adults were encountered who did not report having acquired the infection sometime in their childhood.

Fishman[12] has reported an epidemic of *T. schoenleini* favus among nurses and other personnel of a large city hospital. This epidemic is interesting not only because adults (chiefly girls about 20 years of age) were involved, but also because the infections occurred only on glabrous skin. Fishman believed that the gowns used in common by these nurses were responsible for carrying infectious spores.

There must be factors, however, other than age which determine the acquisition of the infection. This is evident from the fact that not all children acquire the infection, even though equally exposed. Indeed, in one family of three boys and two girls, all under 12 years of age, two boys had the infection whereas the two girls and the third boy (a twin of one of the infected boys) remained free of the infection. The boys slept in a single bed and frequently exchanged clothing.

One case not in this series of patients is known in which the patient dated the onset of his infection with receiving a blow on the head with a hoe. It is interesting to speculate as to whether a break in the skin was responsible for initiating the infection, "inoculating" a trichophyton spore or whether this event was just a coincidence. Perhaps experimental work would be worthwhile to determine whether trauma, e.g. a scratch or break in the skin, is necessary to start a favus infection.

Trichophyton schoenleini has been reported as having been recovered from mice, dogs, hedgehogs and other animals. Almost all of these families kept one or more dogs around the house, but questioning individuals rather carefully did not reveal any evidence of skin infections among the dogs. Mice undoubtedly infest some of these homes, but none were caught to determine if such mice were infected. We do not know what role, if any, was played by animals in these infections. In practically all instances, it appeared most likely that the infection was acquired from another person who harbored an active infection.

One of the objectives of this study was the eradication of favus from the State. With the invaluable help of the local health department personnel, 25 cases were found. These cases were diagnosed, treated and apparently cured. While eradication may sound ambitious, it is not impossible if local health department personnel, private physicians and local fiscal authorities cooperate.

The patients and their parents must also cooperate. During this study, cases of favus were reported from two or three other counties but these patients failed to report. Thus, eradication may not be achieved in Kentucky because of failure to seek treatment.

Summary

1. Twenty-five cases of favus have been located and treated in Kentucky. Most of these are from the Eastern part of the State, and the majority of them had a familial distribution.

2. The organism isolated in these cases was *Trichophyton schoenleini.*

3. The clinical and laboratory diagnosis of favus has been discussed in detail.

4. All of the cases have been clinically cured with griseofulvin, and all cures have been substantiated by laboratory findings.

5. No untoward drug reactions were experienced by the patients during the administration of the drug in the dosages recommended.

6. Two relapses or reinfections were observed along with one "resistant case." All were subsequently cured with further treatment.

7. Although some of these cases have been followed for nearly two years, it remains to be seen whether they will re-acquire the infection or relapse.

* * * * *

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The Physician's Relation to the Practice of Pedodontics

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Louisville, Ky.

Close cooperation between the professions is the key to good dental health in small children. Dental examination and diet supervision should be part of regular medical care.

THE only disease more prevalent than dental caries is the common cold. Ninety-six per cent of the population have dental caries. More important to our subject is the fact that 90% of grade-school children, and approximately 50% of preschool children between three and six years, visiting the physician for preventive care, have one or more carious teeth. Most of these teeth are unfilled.

Many mothers are unaware of tooth decay and will remain unaware of it unless the physician calls it to their attention. Many parents do not seek dental care for their children until a toothache develops. They are usually quite surprised when decay reaches the pulp, causing extreme pain and infection of the jaw. This is hardly a good introduction of the child to the dentist and certainly not in keeping with sound principles of preventive medicine.

Prevention of disease should be the primary goal of every physician. But many physicians feel that dental disease is not within their province and leave examination and care of teeth strictly to the dentist.

This paper will attempt to clarify the role of the physician in the control of dental caries and indicate how he can help the pedodontist and the dental G. P. in a successful program of caries prevention.

Initial Examination

The following steps applied to daily examinations of children in your offices would do more to prevent dental decay and tooth loss than all the toothpaste now sold.

Examine the teeth of every child coming to the office. This can be done just before the examination of the throat and tonsils. One of my pediatrician friends tells me he always tells the child that he is going to look at his teeth instead of at his throat. The time required is about a minute and the only equipment needed is the tongue blade and intra-oral light.

Start with the last lower molar on either side and touch each tooth around the lower arch. The tongue blade also serves to help keep the tongue out of the way. Repeat with upper arch. With small children, it is probably wise to count as you examine the teeth. Count from one to 10 for the pre-school child. There are 10 primary teeth in each arch from two and one-half years of age to about five or six. The first permanent teeth are called six-year molars. The eruption of the six-year molars occurs any time between five and seven years of age. Check the molar teeth carefully since dental caries usually start in the occlusal pits and fissures of these teeth.

If the child has no cavities and is around three years of age, refer him to a dentist with an interest in treating children for early introduction to dental care and to start a program of preventive dental care.

If the child has one or more small cavities, insist that he be taken to a dentist for fillings. Check at the next visit and see if the teeth are filled.

If the child shows many cavities, start caries control measures and refer to a competent dentist at once.

The most effective method of reducing dental caries consists of stopping excessive intake of refined carbohydrates between meals. Review the diet of the child and suggest substituting fresh fruits, cheese, cold cuts of meat for the soft drinks, candy, cookies, white bread and other cariogenic confections eaten in such large quantities by our children between meals. Most children who are feeding problems at mealtimes usually nibble constantly between meals

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and, by the same token, most of these children have a very high incidence of dental caries.

The physician should guide the diet of the preschool and grade-school children with the same care that he does infants. When a child is vigorous and growing well, there is a tendency to omit dietary supervision, but when dental disease becomes evident, it is the physician's responsibility to review the diet with a view toward better dental health and systemic health.

Characteristics of Caries

In order for you to understand the problem of dental caries, I will now review the major characteristics of dental caries, since this disease usually receives only superficial attention in most medical school curricula. If the main features of the disease are understood, it is not difficult to apply the various methods of caries control.

Dental caries is the result of bacterial attack of the hard substances of the tooth, beginning on the surface and progressing inwardly toward the pulp and resulting in the formation of a cavity. The primary attack on the enamel, or dentin, is made by acid metabolites produced by acidogenic organisms (lacto-bacilli, streptococci and others) living on a fermentable carbohydrate substrate on the surface of the teeth. Acid decalcification is followed by proteolysis of the organic matter with the result that dental caries is a slowly progressive and intermittent process.

Dental caries is primarily a disease of childhood. It begins early in childhood and increases as the child grows older, with acute increases between four and eight years, and 12 and 16 years. The rate decreases rapidly after the age of 20 in most cases. Normally, not many cavities develop before the age of three, but in the past several years, I have seen an increasing number of children around two years of age with a high caries incidence.

The most important contributory factor in the initiation and progression of dental decay is the readily fermentable carbohydrate which adheres to the surfaces of the teeth. It is metabolized within a few minutes. The pH on the tooth's surface will drop from 7.0 to 5.4 within two minutes after a single glucose rinse. So, caries control depends on preventing the accumulation of fermentable sugars on the tooth's surface. This can be accomplished by:

1. Restricting the sugar intake to mealtimes, when the natural cleansing of other foods and saliva removes the sugar from the teeth, and,

2. Brushing the teeth immediately after meals.

According to the best scientific evidence no other dietary or nutritional factors make any marked difference in the production or prevention of dental caries. This includes calcium and Vitamin D.

From studies of both human beings and animals there is evidence that hereditary factors also influence susceptibility to decay. Approximately 3 to 4% of the population are caries immune, no matter how poor their oral hygiene. Caries immunity can be traced through family groups.

Rampant caries affect about 7% of the population, even with the best oral hygiene and controlled carbohydrate intake. In this group, poor hygiene and dietary indiscretions are catastrophic and they usually become edentulous by 25. This, too, seems to be familial in nature.

Dental caries begins in the pits and fissures on the occlusal (biting) surface of the molar teeth. These are the most susceptible areas and the physicians should examine these with especial care. In fact we expect to fill 85% to 90% of the occlusal surfaces of all six-year molars. The second most susceptible areas are the proximal contact between the molar teeth. These are hard to examine; even a dentist requires intra-oral x-rays to diagnose these cavities in the incipient stage. The third, and least frequent site for caries attack, are the necks of the teeth near the gingivae.

Dental caries spread from the molar teeth anteriorly. The farther forward in the mouth you see the caries, the more severe the disease. If cavities are seen on the proximal surfaces in lower anterior teeth, it is considered rampant.

The only effective methods of caries control are:

(a) Early and regular visits to the dentist and,

(b) Elimination of fermentable sugars between meals.

A good percentage of caries prevention in children can be accomplished by:

(1) Elimination of fermentable sugars between meals.

(2) Tooth brushing immediately after each meal.

(3) Topical application of fluorides to the enamel as soon as the teeth erupt.

(4) Addition of one part per million of fluorides to the community drinking water.

Prevention and Control

The physician can be of inestimable value in a program of caries control and caries prevention. The physician is regarded as the authority in matters of the child's health. It is his responsibility to refer children for early dental care, *before* the teeth show gross evidence of decay. He can also help in preventing caries by introducing, at an early age, the parent and child to the concept of caries control by regulating the sugar intake. He can nullify the efforts of the dentist in this program by a too casual attitude toward dental health.

Caries prevention and caries control measures are especially indicated for children who suffer dangerous hazards from tooth extractions. This includes children with hemophilia, kidney disease, diabetes and rheumatic heart disease.

Of particular importance, also, is early dental care for cleft palate children. Too often many teeth of these children are lost due to neglect when it is of the utmost importance that they retain every possible tooth. They are needed for proper function, to aid in growth and development of the jaws, and, in cases where the cleft cannot be closed surgically, the teeth are needed for the retention of speech aids and prosthetic appliances.

Excessive sugar intake between meals constitutes a hazard not only to the teeth. Excessive consumption of refined carbohydrates between meals is an important factor in the loss of appetite at mealtimes for essential foods. These foods are high in caloric value and help put the child on a merry-go-round of poor eating habits. The child eats between meals and is not hungry at mealtimes for the meats and vegetables which he needs for normal growth and development. Then a short time later he is hungry again and reaches for his candy or cookies and soft drink.

It is a paradox that we, the best fed nation in the world, have fully half of our children suffering from malnutrition due to the fact that excessive sugars literally push necessary protein, minerals, fats and vitamins from their diet.

The sugar appetite in the child or the alcohol habit in the adult may have many points in common from both the metabolic and psychological viewpoints. Small amounts of sugar and alcohol stimulate the appetite and lead to obesity. Large amounts of both repress the appetite and lead to malnutrition. It is interesting to note that dental decay has its highest incidence in the thin, undernourished child who lives, largely, on between-meal snacks of sweets and starches.

If the child's sugar intake is limited to mealtime, the caries attacks would be lessened by the buffering and detergent action of saliva and alkaline food stuffs. However, when refined sugars are ingested between meals and at frequent intervals, the teeth are subjected to continuous assaults by the acids formed on the tooth's surfaces. It is not so much the total quantity of sugar consumed during the day, as the *number of times* a day a sugar meal is taken that is important. It is better to have an occasional candy or cookie binge than to have the one or two small pieces every day that parents always say their children eat.

Caries control via sugar control should be initiated by the physician as early as possible. This is not difficult if he will obtain a careful history of the daily intake of the child for the period of a week.

Individual immunity is a factor in the amount of fermentable carbohydrates which is cariogenic. A very susceptible child may suffer a great destruction of the teeth from what seems to be only normal amounts of sugars, while other children may consume large amounts of candies without severe damage.

Many parents find it a problem to limit the between-meal snacks and sweets of their children. In many cases this is because the parents themselves consume large amounts of candies, cookies, etc., between meals. An effective technique is to suggest an apple or orange instead of candy or cookies, or a sandwich containing meat or cheese instead of one containing jams or jellies. A healthy child will enjoy these just as much and certainly it is far more healthful. Most young children will select the fruit or meat unless their appetites are already conditioned to sweets.

Again I want to point out that the appetite for sweets is acquired early. A lot of my pediatrician friends give lollypops as rewards to their patients. I tell them this is fine as it increases my practice. However, may I suggest that if you give something to your child patient, let it be a balloon or a trinket instead of the

candy. This is a small thing but it shows that you are not endorsing, or condoning the eating of sweets between meals.

Tooth Brushing

The second preventive measure I mentioned was the tooth brushing after meals. The amount of brushing, the method and timing are far more important than the dentifrice used. It has been shown that regular brushing of the teeth immediately after meals reduced the caries attack rate by as much as 40%. Unfortunately, most people brush on rising and before retiring. This serves only a cosmetic function as it does not remove the food from the tooth surfaces before they form acids.

There is a search for a magic tooth paste which will prevent dental caries. Ammonium-ion, chlorophyll, penicillin and antienzymes have been added to the dentifrices with many promises by the manufacturer that they will halt decay. This has helped the sale of tooth paste, but has not significantly reduced the incidence of dental decay. However, Crest, which is a stannous fluoride tooth paste and was developed at Indiana University, has been proven to reduce decay about 23%. It has been endorsed by the American Dental Association Council on Therapeutics.

Other research is being conducted and it is hoped that other caries preventing or reducing dentifrices will be found. Until that time, the best results are obtained from the tooth brush and the "elbow grease" used rather than the tooth paste. The next preventive measure is topical application of fluorides to the teeth of children. This reduces caries around 40%.

The method of treatment is simple: Following a dental prophylaxis the teeth are dried and a 2% solution of sodium fluoride applied. This is followed at approximately weekly intervals for four treatments. This has very little effect upon the teeth of adults.

Water Fluoridation

The fourth preventive measure is fluoridation of the communal water supply. This reduces caries around 60% by the addition of one to two parts of fluoride per million parts of water. The cost is only about eight to ten cents per person a year. There have been some objections to this, just as there were to smallpox vaccination and other preventive medical treatment, however the objections are purely emotional and not based on any real facts.

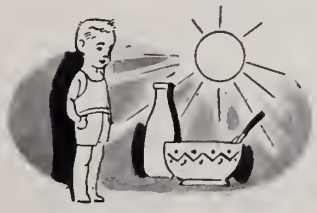
Unfortunately, there are some old wives' tales connected to the practice of dentistry for children. The most common being: "Why fill baby teeth? They are lost anyway."

The primary teeth are needed for two very important reasons: First, to eat with until our permanent teeth erupt; second, to serve as space maintainers to the permanent teeth. The largest single cause of crowded teeth is the early loss of primary teeth without any replacements. This also causes many of the peridontal conditions of later life. Thus early dental care affects your dental health the rest of your life.

A word on referral: The phrase, "Go see your dentist," does not constitute a referral. Many do not go and some go to a dentist who for one reason or another does not like to treat children. Find out which dentists are able and willing to treat children. Your referral should be as definite as your referral of a patient for surgery.

Conclusion

The responsibility for treating and repairing the teeth rests with the dentist. The physician's responsibility is to refer the child for early dental care, help reduce dental caries by controlling diet and helping in acceptance of fluoridation of public water supplies. Dental health is part of the total health picture. No child is perfectly healthy if he is suffering from extensive and destructive dental decay. Dental health is thus a part of general medical care.



Peripheral Arterial Emboli—Early Diagnosis and Treatment

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Lexington, Ky.

A review of peripheral arterial emboli is presented, stressing pathophysiology, early diagnosis and treatment.

ADVANCES in vascular surgery in the past decade have revived interest in the treatment of arterial emboli lodged in major peripheral arteries. Whereas, prior to this period, conservatism was advisable, now a more aggressive approach has resulted in a favorable prognosis in the majority of cases. This is emphasized by the report of Key,[4] who in 1929 reported satisfactory results in 51% of the cases as compared with recent reports[2, 8, 9, 10] showing favorable results in nearly 100% of cases.

The importance of early diagnosis and treatment of arterial emboli has been accepted since Labey[5] performed the first successful embolectomy in 1911. It had been thought, until recent years, that patients with arterial emboli seen 24 hours or more following the occlusion were condemned to loss of life or limb. However,[1, 3, 7, 8] experience has shown this is not always true. Arterial embolectomies have been performed days following the occlusion with successful results in selected cases. However, early removal of the embolus is accompanied by satisfactory restoration of blood flow in the majority of cases, a fact which emphasizes the urgency of early diagnosis and treatment.

It is the purpose of this paper to review the early diagnosis and treatment of arterial emboli and emphasize that results may be improved by prompt recognition and surgical care.

Pathophysiology of Arterial Emboli

Most arterial emboli arise from thrombi which develop within the heart chambers. Two cardiac conditions are outstandingly responsible for the initial origin of the intracardiac clot, namely auricular fibrillation and myocardial infarction. However, intracardiac thrombi may develop without demonstrable cause. An extracardiac source of emboli to the extremities may be advanced atherosclerosis of the aorta.

The underlying heart disease may be rheumatic heart disease, hypertensive cardio-vascular disease or arteriosclerotic heart disease. Patients with rheumatic heart disease have a better prognosis than those with hypertensive cardiovascular disease, the chief reason being that the former have better peripheral arterial arteries than the latter.

Once the embolus has formed it most frequently lodges at an arterial bifurcation. The common sites of embolism in the upper extremity are the innominate bifurcation on the right, and the circumflex axillary branch of either axillary artery, the profunda branch of the brachial artery and the brachial bifurcation, below the elbow. In the lower extremity the common sites of lodgment are the aortic and iliac bifurcations, the origin of the profunda femoris, and the bifurcation of the popliteal artery. These sites of involvement are so common that the extremity signs and symptoms are typical for the site affected. For example, an embolus lodged at the bifurcation of the common femoral artery produces calf pain, blanching of the foot and calf and subsequent numbness and paralysis below the knee. The developing thrombosis proximal to the offending embolic occlusion is short, but distally fills the occluded vessel. This distal thrombus propagates itself, obliterating the collateral supply. In addition, vasoconstriction, set up by reflexes at the site of embolism, further diminishes the effectiveness of existing collateral channels. The result is ischemia of the affected limb.

Diagnosis

A sudden, excruciatingly severe pain in a

limb is the most dramatic symptom of an arterial embolus. The pain is unrelenting and in time is accompanied by numbness, coldness and paralysis of the extremity. The distribution of pain is not along nerve pathways. It is a severe aching, cramping pain in the affected muscle groups. If the occlusion is not relieved a sense of coldness in the extremity ensues, and is accompanied by numbness of the extremity. With the increase in the occlusive process ischemia results. The impaired nutrition of the peripheral nerves causes a sensation different from the initial pain in that it is burning in quality.

The patient finds it painful to elevate his leg and consequently keeps it in a dependent position. The dependency promotes edema of the foot which further impairs tissue nutrition, so that ulceration and gangrene develop.

The most important physical sign of an acute arterial embolus is the absence of pulsation in the arteries of the affected extremities. Absence of femoral pulsations bilaterally is indicative of a complete aortic occlusion, whereas unilateral loss of the femoral pulses points toward occlusion of the common iliac artery. The presence of a femoral pulse with loss of popliteal and pedal pulse indicates a femoral bifurcation occlusion. The point of occlusion is usually found just past the most distal palpable pulse.

The sudden absence of pulsations is accompanied by marked coldness and frequently muscle weakness or paralysis. Oscillometric studies may prove of value in localizing the site of obstruction but are seldom indicated for the establishment of the diagnosis. Arteriography is occasionally useful when the diagnosis is questionable, as in extremely obese individuals or when a palpable pulse is absent because of associated arterial spasm. However, when it is remembered that arterial emboli most frequently lodge at major arterial bifurcations and the point of occlusion is found just past the most distal palpable pulse, the site of occlusion can be localized with a high degree of accuracy.

Treatment

Treatment of arterial emboli lodged at major arterial bifurcations is surgical. Embolectomies performed within 24 hours following the occlusion are successful in nearly 100% of cases, and although emboli of more than 24 hours' duration may be removed, the prognosis as to salvage of limb or even life becomes more guarded. Therefore, early diagnosis and an aggressive surgical approach will be most rewarding. This is particularly true in aortic emboli where non-operative treatment so frequently ends in fatality.

The objective of operative management of arterial emboli is removal of the embolus and clearing of the arterial tree, distal to the obstruction, of the propagating thrombus. Surgery is performed under local or general anesthesia, depending on the condition of the patient and location of the embolus. Most of these patients are critically ill because of the arterial occlusion superimposed on the cardiac problem and therefore the operative risk is often pronounced.

The involved artery is exposed and the embolus identified at the arterial bifurcation by palpation and noting the absence of pulsations distal to the point of occlusion. Proximal blood flow is controlled by use of occluding tapes and a longitudinal incision is made directly over the site of the embolus. With the release of the proximal occluding tape the clot will be thrust through the arteriotomy by the pressure of the column of blood. If the embolus has become attached to the intimal lining of the vessel gentle suction, compression and milking of the vessel may be necessary to extrude the embolus.

Removal of the distal propagating thrombus is a prerequisite to the establishment of a patent artery. The longer this distal thrombus remains, the more organized it becomes and the more firmly it becomes attached to the intimal lining of the vessel. This is one of the reasons for a decrease in the salvage rate in limbs obstructed for 24 hours or more. In an effort to remove this distal thrombus, the procedure of "retrograde flushing" has been developed by Crawford and DeBakey[1] and has proved useful in the author's experience.

Following extraction of the embolus suction is applied, through a catheter, to the distal vessel. If the distal thrombus is short and not attached to the intimal lining, "back bleeding" will ensue with vigor. If, however, the distal thrombus is long, as in cases seen late in the occlusive period, a vessel in the more distal portion of the extremity, such as the posterior tibial or radial, is exposed and a retrograde flushing procedure is performed.

Dilute concentrations of heparin and pro-

caine solution are used as the perfusing agents, heparin for its anticoagulant action, and procaine for its antispasmodic effect. More recently fibrinolysin injected distally or via the retrograde flushing method has been utilized with success in removing thrombi from the small arteries not amenable to direct attack. The arteriotomy incisions are closed utilizing a vein or Dacron "patch graft" in vessels of small diameter so as not to encroach on the lumen of the artery. Concomitant sympathectomy is frequently performed in an effort to enhance the collateral circulation and preserve the viability of the limb, particularly when the success of the embolectomy is in question.

Postoperative systemic anticoagulant therapy is indicated for treatment of the underlying cause of the intracardiac thrombus formation and prevention of further emboli. However, it is seldom necessary in the postoperative period to maintain the patency of the affected artery. Appropriate measures are taken to control the underlying heart disease.

Summary

A review of the problems of peripheral arterial emboli, the diagnosis, pathophysiology and management has been presented, stressing early recognition and prompt surgical intervention.

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An Analysis of 157 Midforceps Deliveries*

Donald L. Ware, M.D. and Hershell L. Clemmons, M.D.**

Louisville, Ky.

Midforceps delivery is a safe obstetric procedure and with proper care and selection of patients should offer no increased risk to mother or infant.

A CONTROVERSIAL obstetrical procedure which has been the object of a good deal of scrutiny in recent years is the midforceps delivery. Some authors[1] feel that the present safety of Cesarean section demands that the traumatic midforceps operation, with its increased infant mortality and morbidity, to say nothing of the maternal trauma, be relegated to obsolescence along with the now extinct high forceps delivery.

The frightening figures of Taylor[2] are certainly a strong argument in favor of discontinuing this procedure. Although his cases were few (31 out of 10,055 deliveries), the perinatal mortality was 26%. In addition, seven other infants received major birth trauma but survived, and 16 mothers suffered a major complication of delivery. This author believes that in his experience oxytocics are safer than forceps in obtaining descent of a presenting part in these cases.

On the other side of the controversy there are reports that with proper selection of cases and due care in management, midforceps deliveries are safe and justifiable procedures. A report by Weinberg[3] of 1,150 midforceps with a fetal mortality of 0.7% is certainly good evidence that in the proper hands the procedure is safe. Another series of 1,000 midforceps,[4] an incidence of 1.9%, reported a perinatal mortality of 2.8% which was less than the over-all infant mortality for deliveries in that hospital.

Other similar but smaller series reported[5, 6] show equally good results and are in agreement that, with due care and selection, this procedure offers no increased risk to mother or infant.

It is manifestly difficult to compare statistics from various centers unless rigid definitions and standards are adhered to by all. Unfortunately, the definition of a midforceps delivery will vary from place to place, as well as from year to year, in the same hospital. This latter variation was found to exist in the material to be presented. At present, however, and for the past few years, the definition of midforceps deliveries is essentially that of Dennen[7] except that no distinction is made between mid and low midforceps.

The material for this study consisted of 16,459 consecutive deliveries, of infants weighing 1,000 grams or more, carried out at the Louisville General Hospital during the period 1954-1959 inclusive. All deliveries were performed by members of the resident staff.

There were recorded during this period 157 midforceps deliveries, an incidence of 0.9%. It is interesting to note that there has been a yearly rise in the number of midforceps coded out. The rise has been more apparent than real, however, as the records indicate a changed concept in the classification of forceps deliveries. Many of the cases in the earlier years of this study in which various forceps rotations were performed were coded as low forceps deliveries. In retrospect, however, a good percentage of these were probably midforceps and would undoubtedly have been so classified by the present resident staff. It is evident that our true incidence is somewhat higher than that given since attempts at re-classification of the cases in question were not made.

There was a preponderance of primigravidas, 104 or 68%, in the cases collected, to 53 multiparas. Term-sized infants numbered 150 to only 7 prematures. The weights varied from 9 lbs. 7 oz. to 5 lbs. 1 oz.

By way of comparison of the midforceps rate and the Cesarean section rate by years, one finds a remarkable consistency in the section rate and in the low forceps rate, but a steadily

*Presented before the Kentucky Obstetrical and Gynecological Society at Lexington, Ky., in 1960.

**From the Department of Obstetrics and Gynecology, Louisville General Hospital, Louisville, Ky.

TABLE I
Forceps and Cesarean Incidence by Years, 1954-1959

YEAR	1954	1955	1956	1957	1958	1959	TOTALS
Deliveries	2770	2679	2737	2686	2801	2786	16,459
Low Forceps	834	690	686	618	599	671	4,098
Mid Forceps	7	10	14	21	43	62	157
Cesarean	57	48	50	59	72	67	353
Incidence:							
Low	30%	25.7%	25%	23%	21.3%	24%	25%
Mid	0.3%	0.4%	0.5%	0.8%	1.5%	2.1%	0.9%
Cesarean	2.0%	1.7%	1.7%	2.2%	2.5%	2.3%	2.1%

increasing midforceps rate. It has been pointed out that the coding or classification differences account for a large part of this change, however, and not, as one might suspect, that the admittedly low section rate is maintained through the increasing number of patients subjected to midforceps delivery. The incidence of forceps deliveries and Cesarean sections by years is given in Table I.

Indications

In the vast majority of the cases the indications for delivery from a midpelvic station were clearly present and conformed to the most widely accepted criteria for this procedure. Commonly more than one indication was operative.

There were 80 instances in the series in which application of the midforceps had as the indication, posterior or transverse position of the occiput and failure of descent below the midpelvis. Fifty of these cases were observed for two hours or more in the second stage before delivery was attempted. The remaining 30 had a second stage between one and two hours long. Of the total, 46 were posterior and 34 transverse.

In 18 cases prolonged second stage alone was the indication. In all of these the occiput was anterior and descent had been arrested for two hours or more in the midpelvis.

The largest group of patients, numbering 26, was that group in which the indication was prolonged labor. Secondary inertia was present in nearly all of these patients. Since there were nine preeclamptics and one eclamptic in this group, the morphine treatment of this disease has to be considered as a possible contributing factor to the prolongation of labor. Pitocin® stimulation was used in 15 of these patients, the indication for its use being inertia, preeclampsia at term, controlled, or ruptured membranes. It is interesting that of a total of 42 x-ray pelvimetry examinations done in the entire series, 18 were on patients in this group. The longest labor recorded was 72 hours.

Fetal distress as evidenced by fetal heartbeat changes accounted for 11 cases. There were also five cases of abruptio or excess bleeding delivered by midforceps in which the element of fetal distress was present or imminent. Three patients were delivered with midforceps after conversion of a brow presentation to an occiput.

Seven cases were classified as iatrogenic midforceps. All of these received saddle block early before complete dilatation and descent had taken place. Three were given Pitocin stimulation to complete dilatation of the cervix. It is, of course, impossible to state what the outcome of these cases would have been otherwise.

Seven patients grouped as "others" in Table II were delivered for various indications. Two were preeclamptic; one of these had Pitocin induction. Both were delivered by rotation and midforceps after a short labor and second stage. One given fractional Pitocin for "inertia" was delivered from the midpelvis after a total labor of eight hours. One was delivered because of marked progressive vulvar edema. One mother with Sydenham's chorea was delivered after a short second stage electively as were the last two in whom the actual indication was resident's training.

TABLE II
Indications for Midforceps Deliveries

Persistent Posterior with second stage two hours or more	25
Persistent Posterior with second stage less than two hours	21
Transverse arrest with second stage two hours or more	25
Transverse arrest with second stage less than two hours	9
Prolonged labor, over 24 hours	26
Prolonged second stage occiput anterior	18
Fetal distress	11
Abruptio or excess bleeding	5
Iatrogenic	7
Brow converted	3
Others	7
TOTAL	157

Deliveries

The Kjelland forceps is by far the most popular instrument used in midforceps operations in this hospital. In this series of cases they were used 76 times. Others used were the Barton's, the Simpson's, the Elliot and the Bailey-Williamson forceps.

Two of the Kjelland rotations failed and Barton forceps were required to complete the rotation and delivery. Also, two other attempts at Kjelland rotation anteriorly failed and the short rotation with delivery occiput posterior was elected. In a good number of Kjelland rotations another forceps such as the Simpson's was used for extraction because of its greater traction ability. The Scanzoni rotation appears only six times in this series and most of these were in the earlier years. While it is true that the Kjelland's has grown in popularity and is at present used almost exclusively in midforceps rotations, this disparity would be less marked had earlier coding conformed to that of the present.

Barton forceps was used in a total of nine cases. These were generally the most difficult and traumatic deliveries of the series. One of the three neo-natal deaths occurred after use of the Barton's and there were three severe maternal complications associated with its use.

There were two instances of Dührssen's incisions both associated with prolonged labors. The Bill's axis traction was used 13 times and the Barton's traction nine times, for a total of 22 cases in which such assistance was necessary for delivery. Various other delivery categories are listed in Table III.

TABLE III
Types of Deliveries by Forceps

Kjelland rotation posterior to anterior	37
Kjelland rotation transverse to anterior	38
Occiput anterior no rotation	36
Posterior delivered as such	20
Delivered posterior after rotation	4
Scanzoni rotation	6
Barton forceps	9
Manual rotation anterior and forceps	2
Dührssen's incisions and Kjelland forceps	2
Conversion of brow and forceps	3
Axis traction	21

Complications

There were no maternal deaths. Fifty-four patients developed some complications of delivery or the puerperium for a complication rate of 34.4%. Major complications such as third degree lacerations, excess blood loss, lacerations of the cervix and shock developed in 29 patients, for a rate of 18%. Five patients suffered more than one major complication. The complications and their frequency of occurrence are shown in Table IV.

TABLE IV
Maternal Complications

Second degree lacerations and/or extensions of episiotomy	18
First degree vaginal lacerations	7
Third degree lacerations	5
Excess blood loss (over 500 c.c.)	14
Lacerations of cervix	13
Endometritis	13
Pyelitis	5
Vaginal hematoma	1
Amnionitis	3
Vulvar edema (marked)	3
Shock (splanchnic)	2

There were four infant deaths in this series, two of which could be related directly to birth trauma. There was one neonatal death due to marked congenital anomalies and one macerated stillborn. The perinatal mortality was 2.6% and the neonatal mortality 1.8%.

Of the deaths, the macerated stillborn delivered from a preeclamptic mother who had an abruptio placenta, blood loss of 1,000 c.c. and hypofibrinogenemia, could be classified as unpreventable. Also in the same category is the death of the infant with hypoplasia of the lung and a large diaphragmatic hernia, who succumbed in the early neonatal period.

The other two deaths unfortunately must be attributed to the delivery. Both infants were autopsied. One death was ascribed to a subdural hematoma. This infant was delivered by Barton forceps from a deep transverse arrest after a two-hour-and-twenty-minute second stage and a labor totalling eight and one-half hours. The infant had marked respiratory distress at birth, subsequently developed convulsions and died on the fourth day of life. The other death was due to a tentorial tear and intracranial hemorrhage in an infant delivered via Kjelland rotation and extraction. There were no difficulties at birth but the infant developed respiratory distress shortly thereafter and expired on the second day of life. The labor in this case was 14 hours with a two-hour second stage. Both were term-sized infants.

The corrected fetal mortality for this series, then, excluding the stillborn and the infant with congenital anomalies which were incompatible with life, was 1.3%. By way of comparison, the over-all mortality rate for section babies was 13.5% or 3% for term babies and 24% for prematures.

TABLE V

Fetal Complications

Deaths:		4
Stillborn	1	
Congenital	1	
Subdural	1	
Tentorial	1	
Late neurological sequelae		
Facial paralysis		3
Marked respiratory distress		8
Cephalohematoma		4
Abrasions and/or forceps marks of face		23
Congenital anomalies		6
Cellulitis of face		1

Concerning morbidity among the surviving infants, there were two significant late neurological sequelae. One infant considered as spastic was delivered by midforceps because of a slow irregular heartbeat. The mother was admitted to the hospital complete and the second stage was of unknown duration. The infant had marked respiratory difficulties and was considered to have a subarachnoid hemorrhage. Although the child survived, it has developed poorly. The other infant has developed convulsions in the first year of life which are as yet not absolutely related to the delivery.

Eight infants exhibited marked respiratory distress at birth. Five of these were associated with preeclampsia, prolonged labors and morphinization. For the other three, however, no good explanation was available. All did well after resuscitation. The remaining complications were all of a minor nature and required no particular treatment. The congenital anomalies were polydactylism, clubbed feet and harelip.

Discussion

The ultimate goal of the obstetrician is the development of methods by which the greatest number of mothers may be safely delivered of healthy infants. All methods and procedures must eventually be judged on the basis of their attainment of this goal. The data presented here show that the method of midforceps delivery stands up quite well by comparison to Cesarean section, and it is still an important and valuable procedure for the obstetrician.

If, as advised by D'Esopo, the section rate were raised, midforceps deliveries would most assuredly be eliminated. The experience in this hospital, however, dictates no such undertaking. Admittedly the incidence of major maternal complications seems high in this series. This is a matter of small moment, however, if by careful attention to management of these patients they can be delivered vaginally with good fetal results. The avoidance of Cesarean section with its subsequent limitation of the childbearing function can be an important consideration in these cases. It is worthy of note that many of the patients in this series have subsequently delivered one or more times without difficulty although two patients in the group were delivered by Cesarean section with their second pregnancies. This indicates that in the vast majority of cases the proper decision for delivery was made. Therefore, it must be stated that with proper selection of the patients, the carefully performed midforceps delivery should remain a definite part of modern obstetrics.

Summary

1. An analysis of 157 midforceps deliveries performed by residents at Louisville General Hospital during the period 1954-1959 inclusive, is presented. The incidence was 0.9%.

2. The incidence of major maternal complications was 18%. There were no maternal deaths.

3. There were four infant deaths; however, only two could be attributed to the deliveries. The corrected fetal mortality rate was 1.3%.

4. Kjelland forceps is by far the most popular instrument used in midforceps operations in this hospital.

Conclusions

The experience at this hospital indicates that midforceps is a safe and satisfactory procedure. The continued use of this method is justified. The maternal complications are significantly high and attention should be directed toward improvement of this. It is apparent from the section rate and the midforceps incidence that a conservative brand of obstetrics is practiced in this hospital. The generally satisfactory mortality and morbidity figures would seem to justify this practice.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Tularemia

Walter T. Hughes, M.D.

A 13-YEAR-OLD white male was admitted to Louisville General Hospital because of enlarged and tender lymph nodes in the left axilla and epitrochlear area.

The sequence of his illness had progressed in the following manner.

On November 23, he was well and went hunting. He killed, skinned and dressed a wild rabbit.

On November 25, he began to have a headache, was nauseated and vomited.

On November 26, he experienced chills and fever and observed a tender "knot" in the left armpit.

On November 27, the left epitrochlear nodes became enlarged and a small pustule appeared on the middle finger of the left hand.

During the next few days the fever gradually regressed and pain in the left side of the chest appeared.

At the time of admission on December 6, the temperature was 98.6° F. orally, pulse was 100/min., respiration was 16/min. and the blood pressure was normal. The pharynx and tonsils were inflamed but no exudate could be seen. Moist rales were heard in the left lung base. There was an ulcer, 1.0 centimeter in diameter, on the dorsum of the left middle finger. A large, firm node was palpated in the left axilla and another was prominent in the epitrochlear region. Both nodes were tender.

The white blood cell count was 13,200/mm^3 with 64% neutrophils, 2% eosinophils, 28% lymphocytes and 6% monocytes. The hemoglobin was 13.0 grams % and the cerebrospinal fluid was normal.

Roentgenogram of the chest at the time of admission revealed accentuated hilar and perivascular markings bilaterally with an infiltrate in the left lung field.

Agglutination tests for *Pasteurella tularensis* were negative at the time of admission. Two weeks later a rising titer of 1:640 was demonstrated, confirming the clinical diagnosis of tularemia.

Therapy with intramuscular streptomycin was initiated on the 19th day of illness and continued through the 25th day. This produced very little change in the lymphadenopathy although the cutaneous ulcer healed and remission of the chest pain and cough ensued.

The patient was discharged on the 28th day of illness only to be readmitted two weeks later (42nd day) with large, tender, inflammed and fluctuant left epitrochlear nodes. The left axillary node was the size of an almond, not inflamed, tender or fluctuant. The patient was afebrile and held his arm in semi-flexion.

Roentgenogram of the chest revealed a small area of infiltrate in the left cardio-phrenic angle which was only slightly smaller than that seen on previous films. Streptomycin was given intramuscularly for seven days. Approximately 200 milliliters of gray pus was drained from the epitrochlear abscess over a four-day period.

By the 51st day of illness the axillary node was fluctuant and incision permitted 30 to 40 milliliters of pus to exude. By the end of the second month of disease, drainage had ceased, the lesions were almost healed and the chest was normal to auscultation.

Comments

Walter T. Hughes, M.D.

Tularemia, also known as Rabbit Fever, Deer-Fly Fever, Plague-like Disease of Rodents and O'Hara's Disease, is one of the few bacterial diseases discovered in America by an American. In 1911, McCoy and Chapin[1] first identified the causative organism of a plague-like disease in ground squirrels and named it *Bacterium tularense* after Tulare County, California, where the diseased animals were first found and where, incidentally, tularemia is rarely seen today. The bulk of our knowledge and understanding of this disease we owe to the long and efficient work of Edward Francis who labeled the condition "tularemia." Today the disease is recognized in all parts of the United States and in most foreign countries.

The causative organism, *Pasteurella tularensis* (*Bacterium tularense*) is a very pleomorphic, nonmotile, Gram negative coccobacillus that is quite virulent and can penetrate the intact skin. The organism is harbored in a large variety of animal hosts. It

has been estimated that 90% of the infections in the United States follow exposure to secretions or tissues of the cottontail rabbit, jack rabbit and snowshoe hare. Ingestion of infected meat and transmission by such insect vectors as the deerfly, horsefly, ticks, lice and fleas are sometimes responsible for infection in man. Man to man transmission does not occur. I have seen several cases of tularemia in laboratory personnel working with cultures of *asteuella tularensis*. In all of the cases of tularemia admitted to Louisville General Hospital in the last 20 years the rabbit has been implicated as the source of infection when a source could be determined.

Tularemia is a severe systemic disease, resembling plague in many ways, which may involve any or all organs of the body. However, the most pronounced reaction is at the portal of entry of the infection, and this has formed the basis for classification. Six types are now recognized:

1. Ulceroglandular
2. Oculoglandular
3. Pulmonary
4. Glandular
5. Typhoidal (Gastrointestinal)
6. Oropharyngeal

The ulceroglandular type is much more common than any of the other types. The patient presented above represents the ulceroglandular type with dissemination to the lung. In one series of patients we have studied, 38.5% of the cases in children were of the oropharyngeal type.[2]

General manifestations of fever, chills, headache, anorexia, vomiting, muscle aching and prostration may be present in any of the types.

Diagnosis can usually be made by clinical findings and confirmed by rising agglutination titers. Skin tests are helpful but not entirely reliable. Attempt to culture the organism poses a potential hazard to personnel in the general hospital laboratory and is not necessary for diagnosis.

Therapy should consist of streptomycin in doses of 20 to 30 mg. per kilogram of body weight per day for one week. Response to this drug is dramatic and the patient is usually afebrile within 48 hours if therapy is started in the acute phase of the disease. As this case illustrates, if streptomycin therapy is initiated 2 or 3 weeks after the onset of illness, response is less likely to be as effective and may have little influence on the subsequent course.

Isolation of the patient is not necessary.

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SPECIAL ARTICLES

The Doctor As A Citizen

LEONARD W. LARSON, M.D.

President, American Medical Association

I HAVE been asked to talk on "The Doctor as a Citizen." I am happy to do so. I also can speak on "The Storekeeper as a Citizen" and I am very good at "The Plumber as a Citizen." Believe me, I am not being facetious: The point is simply that there should be only slight differences in the manner in which any of us fulfills his role as an American. The basic rights and duties are there for all regardless of their background or business. Beyond these, our particular training fits us for service in a particular way and it is here alone that the differences should lie.



Doctor Larson

Every American shares those "certain inalienable rights" which guarantee our life and liberty. We have free elections; we worship God as we see fit; our property is our own. In return there are basic obligations which most of us meet. "Mr. Average" abides by the law—give or take an occasional parking ticket. He sends his children to school; he respects the rights and property of others. He has a license on his marriage, his car and his dog —and most of us would renew all three. He stands up for "The Star Spangled Banner," and he pays his taxes. He can say he is a citizen and no one can deny it.

But this "Mr. Average" doesn't know the pride of participation he *could* feel with a little extra effort. He doesn't know what it's like to jump into citizenship with both feet by taking part in the life of his community, his state and his nation. He doesn't realize what he could be doing for himself as well as for his neighbor.

Whether I am a baker or tailor, a lawyer, doctor or truck driver, my fellow Americans need me—not as a guest, but as a *working partner*. Yet we are developing an alarming number of these "permanent guests" in this country. This is our national enigma: At a time when our nation faces greater danger than at any time in our history, too many of our people have come down with a serious case of lethargy. They are convinced that they don't count, so they refuse to try.

Some sociologists blame this problem on the rather titanic proportions which life has taken on since World War II. The old home town has stretched *out* and *up*, and the world has shrunk until it fits into the TV set in our living rooms. Everything around us is bigger or faster, brighter and costlier than ever before. We have more of everything, but less of everything, too: We have more money but less buying power; more time-savers and less time; more national strength and less security; more family togetherness and less understanding. But this is life in the 1960's and it must be lived. To live it, we have two choices.

We can let it make us feel small and ineffectual. Like "Mr. Average" we can reason that nothing I can do could possibly change anything. I can withdraw from life around me. I can refuse to serve on a committee because someone else will do it if I don't. I can withhold my financial support from my political party or charity because with all that money coming in, no one will miss my share. I can stay home from the polls on election day, because my vote is unimportant. Like the child on the sidelines of the game who pretends he wants no part of it because he's afraid to try, poor "Mr. Average" can sit back and watch.

Or he can take his second choice. He can get in and pitch, use his abilities and his citizenship, and he can be amazed!

For he will realize almost immediately that he *does* count. Simple arithmetic will show him that *his* effort plus another's, or those votes minus *his*, are the key to all that is happening in America today—good or bad. What is accomplished—in government, science, education, literature, communication or plain living—gets done by people no bigger than Mr. Average. The only difference is that they are *active* citizens. He will learn, aslo, that the unfortunate aspects of life—corruption in high places, the decline in public morals about which Mr. Eisenhower spoke only recently—these things, too, are being perpetrated on America by people no more powerful than you and I.

We could stop them if we worked at ethics as hard as they work at immorality. Nothing good gets done without my support as a citizen. Nothing bad can get by unless I turn my head the other way.

Those facts are recognized by the *working partners* in our neighborhood or our nation. Teddy Roosevelt said that a citizen is "one who is willing and able to

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Delivered at the Building Dedication Ceremonies of the Kentucky State Medical Association at Louisville, Ky., May 20, 1962.

pull his own weight." That is *all* he need do to be effective—just pull his *own* weight. And the pull may be much easier than he supposed, once he overcomes the inertia of sitting and watching.

What, then, is the job of the barber, the engineer, the doctor as a citizen? First of all, he must be "up and doing." He must be aware of what is going on around him, know the workings of his government on all levels. He knows his elected officials and their records. He *supports* as vocally as he criticizes. He respects authority, but he is not to be intimidated, for he is aware that authority is placed in the *few* by the consent of the *many*. He knows, too, the truth in those lyric lines which say:

"Oft the statesman and the saint

"Think they're doing good—but ain't."

He knows that he, as a citizen, helps to control the actions of his senator or his union steward, his school board or his Congress. But he cannot have a share in that control unless he earns it.

How does he work to earn it? By giving of his brains and his brawn, if necessary, to his neighbors. He will serve on committees, be they civic, charitable, political or religious. Within the limits of his available time, he'll work as hard for one group in which he believes as for another: He'll serve on the P.T.A. as enthusiastically as he will with his political party. He's as active in his church as in his favorite social club. Each community offers its citizens individual opportunities for service to society and, as I said earlier, each profession or field prepares a man to offer his services in a special way. For example, what can the doctor as a citizen do in facing up to the broad issues of our time over and above his professional duties?

In the first place, the lengthy and intense medical education he has completed has equipped the physician to assemble, sort and evaluate information, to reject non-essential facts and to arrive at sound, logical, unbiased conclusions. This can make him an asset to his community in dozens of ways—on service clubs, Chambers of Commerce, citizen committees, youth programs such as 4-H clubs, Boy and Girl Scouts.

Secondly, the physician in his daily work becomes familiar with people, their weaknesses, their hopes, their frustrations. This is another necessary qualification for any kind of intelligent appraisal of current problems.

In his everyday work, the physician also comes to recognize the needs of the whole community—in such fields as public health services, sanitation, living conditions, recreational facilities, child training, child psychology and countless other aspects of the general environment, and he is thus excellently equipped to volunteer his understanding and aid in solving these difficult problems.

This fine new building which we dedicate today is a tribute to the citizenship of the 2,000 physicians of the Kentucky State Medical Association. It is not a building for their private use, but rather it is one, paid for by them personally, from which will come more efficient service to the medical needs of the entire state. Its convenience for meetings, its greatly increased working area, its beauty will add to the use given it by its members, and with this use will come added medical knowledge, information on new methods of combating illness, consultation with learned colleagues to the great good of the people. Here is a civic contribution in the finest sense of the word!

I believe that the spirit behind this building is typical of the citizenship shown by the medical profession since the founding of our nation, dating back to the five doctors who were among the signers of the Declaration of Independence. Doctors have served on presidential Cabinets and the profession as well as the AMA as a body has been instrumental in originating or active in support of such beneficial legislation as the Kerr-Mills Medical Aid for the Aged Law passed in 1960; Hill-Burton hospital construction program; the passage and strengthening of the pure food and drug laws; the White House Conference on Aging in 1961; FHA mortgage guarantees to stimualte construction of more nursing homes; civil defense programming and medical stockpiling, water and air pollution control laws, tax deduction for medical expenses incurred on behalf of dependent parents over 65 and countless other laws and nationwide undertakings.

Incidentally, when "The Greatest Show on Earth" opens in Madison Square Garden in an hour or two, the nation is liable to hear the repeated and erroneous accusation that the AMA takes the attitude that "whatever it is, I'm agin it." Thus, for the record, may I here point out that during the 86th Congress, the AMA issued 43 statements on 25 bills concerning health, of whcih only six on four bills were in opposition to the legislation. Eleven were informational and 26 were in support of legislation. This is typical of its support of good health measures over the years.

In recent years many independent doctors' groups also have formed around the country to work in behalf of good government at the local level and to elect candidates who stand for those democratic prinprinciples of government in which we believe.

As I said before, it is most important that none of us as citizens—in groups or individually—limit ourselves to action only when particular issues arise. If we operate on that basis, we are vulnerable to the charge that we are acting in self-interest; that we become aroused only when our privileges or pocketbooks are threatened. But if we maintain a steady, nonpartisan interest in local, state and national affairs, demonstrating that we are sincerely concerned over all aspects of the public welfare—then our opinions as citizens will gain greater attention and respect when an issue arises in which we have a particular interest.

Good citizenship is a five-part program. It is accessible to each of us, profitable to all of us. It is a simple program. To be a good citizen one must:

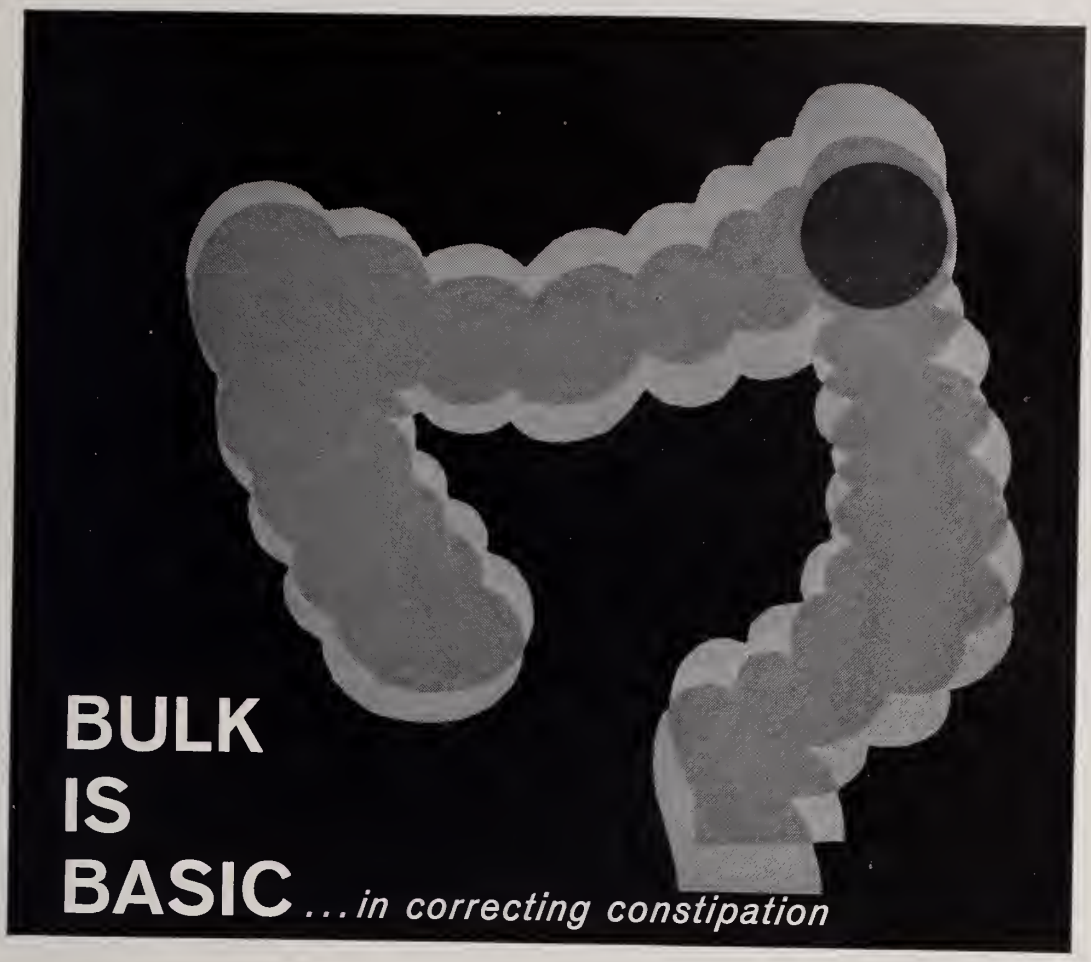
1. Become informed on what is going on around us.

2. Make our knowledge known—by talking to our friends, our patients, clients or customers; speaking to them with the certainty of knowledge and the logic of fact.

3. We must *act*. We must join groups—"pull our own weight" in clubs, associations, businesses.

4. We must *lead*, when it is necessary to take the

(Continued on Page 696)



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The Governor Attends

GOVERNOR Combs honored us on May the 20th by attending the dedication of the Kentucky State Medical Association's new office building in Louisville. He found many of his staunch friends and loyal supporters there and greeted them personally with his usual warm and cordial smile. He gave a brief but inspiring address full of understanding and encouragement. The pressure of his official commitments caused him to leave immediately after his talk. We were disappointed that he was not able to spend a longer time with us but grateful that he came.

It was a matter of considerable disappointment for us to learn that in the same week the Governor had signed a proclamation setting forth the week of May 20th, 1962 as "Medical Care for the Aged through Social Security Week." It would appear that in so doing he placed his state administration squarely behind the President's effort to accomplish the Social Security medical care legislation now before congress.

There is little doubt that the great majority of physicians in Kentucky supported and voted for the Governor in his second campaign. It is our personal knowledge that some physicians who did not support him have expressed confidence and satisfaction in his administration as Governor to date.

We cannot but feel that Governor Combs is a staunch friend of the medical profession and sympathetic to their objectives of private enterprise and personalized high standard medical care to the people of this State. Issues relating to health fared very well in the 1962 legislature. There seems however, to be divergence of his opinion from our view point in the present issue. Let us hope that is purely political.

We continue to endorse and applaud the many fine accomplishments of his administration but disagree with his expressed views on the present issue. The trend of public opinion seems now to favor our position.

Sam A. Overstreet, M.D.

The Patient Will Profit Most

FULFILLING a need of longstanding, the American Medical Association is to be commended for establishing a Department of Medicine and Religion. The purpose of this new agency will be to coordinate the efforts of physicians and clergymen.

The new department, created by action of the AMA Board of Trustees, will be headed by the Rev. Dr. Paul B. McCleave. An advisory committee composed of leading physicians and clergymen across the country has been formed and will be chaired by Milford O. Rouse, M.D., Dallas, Texas, who is vice-speaker of the AMA House of Delegates.

"How to provide health care for the 'old man'—that is the chief concern of the new department," said Dr. McCleave. He feels that too often this is overlooked. "We forget the patient and parishioner's need in total health —physical, mental and spiritual. The three are inseparable," Dr. McCleave says. "Best patient care is achieved when the physician and clergymen are able to share mutual concern for the patient and when each contributes his special talents to the problem at hand," is the philosophy of Dr. McCleave.

The promotion of close physician-clergy relationships are programs developed and carried out by the local county medical society and designed to meet the needs of the community is a part of the new department's blueprint for its future work.

Nine states have been chosen for the development of a pilot program. They are Arizona, Georgia, Iowa, Maryland, Montana, New York, Ohio, Texas and Utah. The new department will work through these state and county groups.

The details of the broader pilot program will be developed locally.

Other objectives of the new department are creation of leadership teams at the state level composed of physicians and clergymen that will include psychiatrists and hospital chaplains at the state level. These teams will give programs to medical and religious groups and demonstrate how better patient care can be provided through team work.

Promotion of closer relations between clergymen and members of their churches in order to discuss health and spiritual programs will be another key objective. It is expected that editorials and articles for religious and medical publications will be a part of the department's work.

In addition, the new agency will seek to foster close relations with hospital chaplains, mental health authorities and pastoral clinical training centers in order to furnish all possible assistance. Dr. McCleave looks forward to establishing similar liaison with medical, theological and nursing school curriculum.

We are glad to see the AMA assuming a position of leadership in this area. In our preoccupation with our immediate patient responsibilities, not always but far too often we overlook the opportunities to render a broader service by failing to recognize and utilize spiritual values. The practical and carefully evolved objectives of the AMA's new Department of Medicine and Religion should provide all of us not only with the vehicle but generate within us the desire to cooperate with our patients' spiritual leaders. This is the kind of cooperation in which all parties will benefit—especially our patients.

Not By Bread Alone

WITHOUT experienced and effective leadership during the past 30 years the medical profession and the American people would now be in a sad state. Three times the national administration in Washington has made concerted and sustained efforts to promote government control of medical care. The present crisis is but a repetition in a somewhat different form of the efforts made in the late thirties and in 1948-49 to federalize medical practice.

Dr. Irvin Abell was one of the strongest leaders in opposition to socialization of medicine during and following his presidency of the American Medical Association in 1938-39. Dr. Elmer Henderson, another Kentuckian, had come to a position of leadership in 1948-49 and led the fight successfully against the Murray-Dingel-Wagner legislation. He was president of the A.M.A. in 1950-51.

We are now indebted to the leadership of no less experienced or less effective officers than those eminent men of the past. As a matter of fact the present issues demand a broader perspective and a more comprehensive grasp of the problem, and more energetic efforts, than did our previous crises. We are fortunate, however, that men of wisdom, experience and energy are in commanding positions now.

Leadership is not developed over night and often cannot be found in an emergency. It must be trained.

The American Medical Association used foresight and wisdom twelve years ago when it sponsored the organization of the Student American Medical Association and encouraged the formation of chapters in all Medical Schools. The objective was to call the students' attention early to current issues, not only scientific but social and economic, which confront us, and to begin in their formative years to train them for leadership.

There are now chapters of the Student AMA in 76 Medical Schools with more than 20,000 student members and a total membership of about 50,000, including Interns and Residents. At the Washington Meeting this year 63 delegates and 55 alternate delegates were in attendance. Their deliberations were favorably reflected in a number of resolutions adopted and forwarded to the AMA. These are published in *The New Physician,* official organ of the Association. These resolutions indicate a wide range of interests in medicine and socio-economic issues, maturely considered.

The student who participates in the activities of the Student AMA, attends its meetings, reads its Journal or occasionally attends its national

terest in medical issues that is not often shared by the non-member student.

For ten years the Southern Medical Association has sponsored the attendance at its annual meeting and participation in its counsels of representatives from every medical school in the South. This has been a surprisingly effective method of encouraging the interest of medical students in the activities of the SAMA and in recruiting new young members.

The KSMA for the past five years has sponsored one day of activities for the senior class at the University of Louisville School of Medicine. During that day of scientific and social contact the senior students have had an opportunity to learn much from clinicians with whom they are shortly to be associated.

The American College of Physicians, The American College of Surgeons and other national specialist organizations, and the American Academy of General Practice have sponsored the attendance and participation of interns and residents at their local and national meetings, thereby offering a practical insight to these young guests into the activities of which they will so soon be a part.

This attention of medical organizations to students and trainees is bearing fruit. It is an effective means of recruitment and training for future leaders. Such efforts could well be expanded.

Man cannot live by bread alone—neither can physicians survive in a purely scientific and clinical atmosphere; we must also come to grips with our social and economic problems. It is well to find and begin to train our future leaders early. The next generation will need men of experience and energy as surely as we have needed our eminent medical statesmen of the past and present.

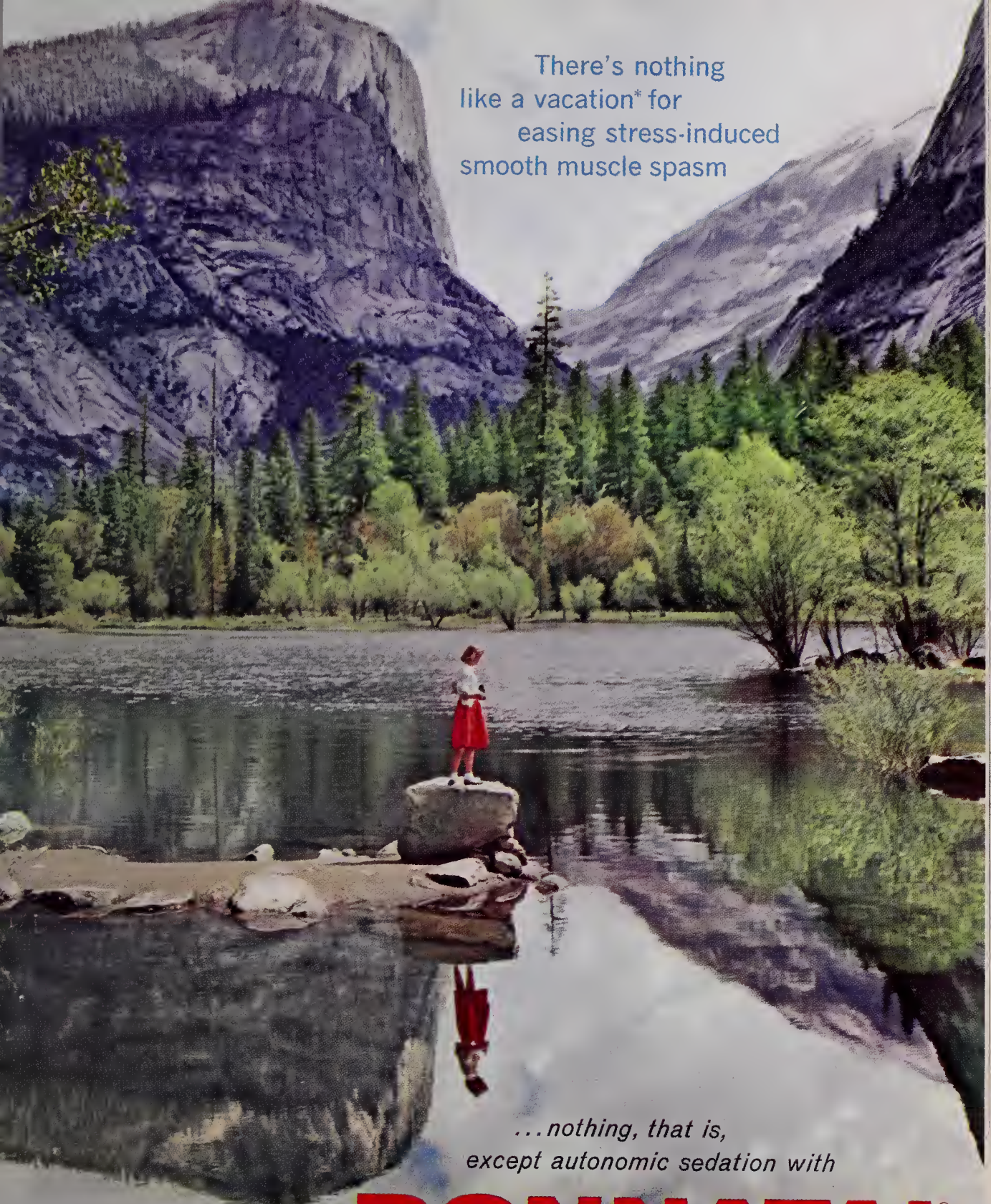
Sam A. Overstreet, M.D.

A Pledge for Kentucky Physicians

I do solemnly swear that I will make every effort to attend the 1962 KSMA Annual Meeting in Louisville on September 18, 19, and 20—and with this pledge, I promise to take immediately action by:

1. *Circling September 18, 19, and 20 on my calendar*
2. *Making arrangements for another physician to handle my practice*
3. *Writing for hotel reservations, if needed*
4. *Notifying patients that I will be out of the office for purpose of adding to my medical "know-how"*

Recognizing that the objective of the Association's Annual Meeting is to contribute to my medical knowledge by providing a varied, interesting and valuable program of postgraduate medical education, I hereby pledge myself to take an active interest in all scientific sessions, exhibits, and in all phases of the program leading to the advancement of the KSMA and the profession of medicine.



There's nothing
like a vacation* for
easing stress-induced
smooth muscle spasm

...nothing, that is,
except autonomic sedation with

Prescribed by more physicians
than any other antispasmodic

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Natural belladonna alkaloids plus phenobarbital

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In each DONNATAL Tablet, Capsule or 5 cc. Elixir		In each DONNATAL Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

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DONNATAL EXTENTABS®
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as each patient may require

—**for dramatic promptness:** ROBAXIN INJECTABLE usually provides relaxation of painful spasm *in minutes.* Clinicians have reported that it is "effective in producing immediate relaxation,"[7] and brings about "dramatic relief of pain and spasm" within 15 to 20 minutes.[3]

In each 10-cc ampul Methocarbamol (Robins) 1.0 Gm.

—**for prolonged use with safety:** ROBAXIN TABLETS safely maintain relief of spasm *without drowsiness.* "The effect does not wax and wane,"[4] and continued administration shows "no deleterious effect on normal muscle tone."[6]

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—**for concurrent analgesia:** ROBAXISAL TABLETS, combining ROBAXIN with aspirin, are useful in spasm-triggering states that are painful in themselves, or when pain is prominently associated with muscle spasm.

In each pink-and-white laminated tablet Methocarbamol (Robins) 400 mg.
Acetylsalicylic acid (5 gr.) 325 mg.

—**for concurrent analgesia plus sedation:** ROBAXISAL-PH TABLETS, combining ROBAXIN with the sedative-reinforced analgesic PHENAPHEN®, are particularly helpful in giving comprehensive relief to patients in whom muscle spasm is accompanied by spasm-potentiating pain and apprehension.

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Methocarbamol (Robins)	400 mg.	Acetylsalicylic acid (1¼ gr.)	81 mg.
Phenacetin	97 mg.	Hyoscyamine sulfate	0.016 mg.
		Phenobarbital (⅛ gr.)	8.1 mg.

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References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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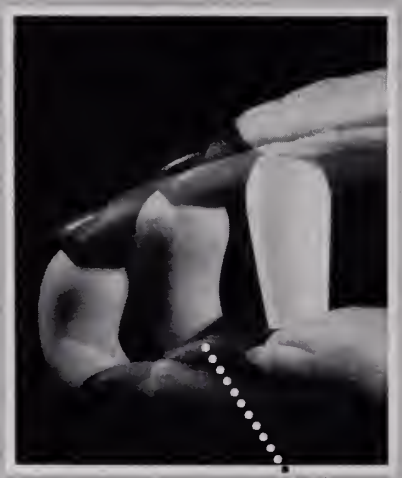
"...high therapeutic effect..."[5]

"...superior to other relaxants..."[9]

"...remarkably effective..."[2]

"...a high potential for prompt relief..."[8]

"...unusual freedom from toxicity..."[1]



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proved therapeutic action* in an exception
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non-staining. The course of treatment of vaginit
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are supplied in boxes of 10 with applicato

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ORGANIZATION SECTION

Dr. Simpson Announces Speakers for '62 Annual Meeting

Stressing the postgraduate educational benefits to be obtained from attendance at the 1962 KSMA Annual Meeting on September 18-19-20, Gaithel L. Simpson, M.D., urged all Kentucky physicians to attend.

Calling the 1962 program "outstanding," Doctor Simpson released the names of four featured speakers who will speak at the general sessions as guests of various specialty groups.

Speakers include guests of the Kentucky Chapter, American Academy of Pediatrics; Kentucky Anesthesiology Society; Kentucky Chapter, American College of Chest Physicians; and the Kentucky Chapter, American College of Surgeons.

William A. Silverman, M.D., guest of the Kentucky Chapter, American Academy of Pediatrics, will participate in a panel discussion at 9 a.m. on Wednesday, September 19 at which he will discuss the pediatric aspects of the "Management of Thoracic Emergencies." He will also address the pediatric group meeting on Tuesday afternoon, September 18.



Dr. Silverman

Doctor Silverman, a graduate of the University of California Medical School in 1942, is an associate professor of pediatrics at Columbia University. In 1959 he received the Mead Johnson Award for research in pediatrics.

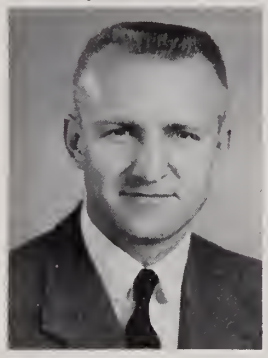
Ray T. Parmley, M.D., director of the department of anesthesiology, of St. Francis Hospital, Wichita, Kan., will be the guest of the Kentucky Anesthesiology Society. He will address that group at its specialty meeting on Tuesday, September 18 in the afternoon. A participant in a panel on "Management of Heart Disease in Pregnancy," he will present the anesthesiological aspects of this problem at 9 a.m. on Tuesday, September 18.



Dr. Parmley

Doctor Parmley is assistant clinical professor of surgery (anesthesiology) at the University of Kansas Medical School, Kansas City, Kansas. A graduate of Tulane University, he is vice president of the Southern Society of Anesthesiologists and a diplomate of the American Board of Anesthesiology.

R. Drew Miller, M.D., consultant in medicine in the Mayo Clinic and associate professor of medicine in the Mayo Foundation as well as its associate director, is coming to the meeting as the guest of the Kentucky Chapter, American College of Chest Physicians. He will address that group on Tuesday afternoon, September 18. On Wednesday morning at 9 a.m. he will participate in a panel discussion on "Management of Thoracic Emergencies."



Dr. Miller

A native of Chicago, Doctor Miller graduated from Northwestern University Medical School in 1945 and was certified as a specialist in internal medicine in 1953 by the American Board of Internal Medicine and as a specialist in pulmonary diseases in 1955.

Guest of the Kentucky Chapter, American College of Surgeons will be E. Stanley Crawford, M.D., associate professor of surgery, Baylor University College of Medicine. A graduate of the Harvard Medical School with an M.D. degree in 1946, he is a member of the American Board of Surgery and the Board of Thoracic Surgery.



Dr. Crawford

Doctor Crawford will address the Kentucky Chapter, American College of Surgeons on Tuesday afternoon, September 18 and will also discuss the surgical aspects of the "Management of Thoracic Emergencies" on Wednesday, September 19 at 9 a. m.

Full coverage of the 1962 Annual Meeting will be carried in the August Journal—the Annual Meeting issue.

New Medical Center Phone No.

On July 1, the telephone number of the University of Kentucky Medical Center will be changed to 5-3600.

AMA President at Dedication of New KSMA Headquarters

See photos on opposite page

"This fine new building is a tribute to the citizenship of the 2000 physicians of the KSMA," said Leonard W. Larson, Bismarck, N. D., AMA president, at the dedication of the new headquarters building of the Association on May 20.

Two hundred physicians and invited guests attended the deication ceremonies which featured Doctor Larson as the keynote speaker (his address appears as a special article on pages 669-670) and addresses by Governor Bert T. Combs and Mayor W. O. Cowger, Louisville.

Governor Combs commended the KSMA and its members for "their active efforts to make Kentucky a healthier and safer state in which to live." Mayor Cowger called the building an asset to the community and also lauded the KSMA for its many projects in the public interest.

Master of ceremonies for the dedication was George F. Brockman, M.D., chairman of the building committee. Gaithel L. Simpson, M.D. Greenville, KSMA president, expressed the appreciation of the entire Association to Doctor Brockman and the other members of the building committee for work well-done. He accepted the keys to the new building from the contractor Stanley Lichtefeld and congratulated him and the architect for their parts in making the new headquarters a reality.

A special feature of the dedication was the cutting of the ribbon on the door of the new headquarters with a special pair of gold bandage scissors presented to the Association by the Mississippi State Medical Association. Mississippi was one of the state medical associations visited by the building committee when the new headquarters office was still in the planning stages.

Prayer of dedication was given by Wyatt Norvell, M.D., New Castle, chairman of the KSMA Board of Trustees. The ceremonies outside the building were followed by a tour of the building and serving of refreshments.

A montage of pictures taken at the dedication appears on the next page.

1. Past presidents of the KSMA had front row seats at the dedication ceremonies on May 20. From left to right—Hugh L. Houston, M.D., Murray; Guthrie Y. Graves, M.D., Bowling Green; Richard R. Slucher, M.D., Buechel; Robert W. Robertson, M.D., Paducah; E. M. Howard, Jr., Harlan. Present but not shown is J. Duffy Hancock, M.D., Louisville.

2. Acting as master of ceremonies at the dedication was George Brockman, Greenville, chairman of the Building Committee.

3. AMA President Leonard W. Larson, M.D., Bismarck, N.D., addressed the dedication gathering.

4. Doctor Larson, AMA president, signs the Dedication Guest Book as Building Committee Chairman George Brockman, M.D., looks on.

5. Cutting the ribbon with shears presented to the KSMA by the Mississippi State Medical Association were Mayor William O. Cowger, Louisville; Dean J. Murray Kinsman, M.D., U of L Medical School, and Dean William R. Willard, M.D., of the U of K College of Medicine.

6. KSMA President (left) Gaithel L. Simpson accepts the keys to the building from Stanley Lichtefeld, contractor.

7. Governor Bert T. Combs praises the Association for its cooperation with the State in the interest of the public's health.

8. Enjoying the refreshments were—Carl Cooper, M.D., Bedford; Otis L. Wheeler, director of Jewish Hospital, Louisville; State Representative Charles E. Gaines, Louisville; State Senator Vernon C. McGinty, Louisville. In the background are Lipton Klein and Mrs. Klein caterers and Bob Johnson of the U of K public relations department.

9. Studying the dedication program are—John H. Walls, M.D., Jesse Bell, M.D., and Jacob A. Gay, D.D.S., all of Louisville. At the right foreground is former KSMA President J. Duffy Hancock, Louisville, in conversation with KSMA Vice President Henry B. Asman.

British Panelists Picked For Transatlantic CPC

The official line-up of the British team of physicians who will participate in the Transatlantic Telephone Clinicopathological conference on Renal Disease during the annual meeting of the Kentucky State Medical Association September 18-20 has been released for publication.

According to Gaithel L. Simpson, M.D., Greenville, KSMA president and chairman of the Council on Scientific Assembly and Arrangements, and Edmund D. Pellegrino, M.D., Lexington, chairman of the program committee, the panel will include:

Arthur Henry Jacobs, F.R.C.S., F.R.F.P.S., moderator consultant, Royal Infirmary, Glasgow.

William Sommerville Mack, F.R.C.S., senior consultant in urology, Western Infirmary, Glasgow.

Arthur Kennedy, M.D., lecturer, University of Glasgow, consultant, Royal Infirmary.

John Basil Rennie, M.D., F.R.C.P., F.R.F.P.S., lecturer, clinical medicine, University of Glasgow.

A group of Louisville physicians will engage in the panel discussion with the British doctors.

The Transatlantic CPC Conference is scheduled for 2 p.m., Wednesday, September 19. It is sponsored by Smith, Kline & French, Phaladelphia.

Doctor McCarty Honored

A. Clayton McCarty, M.D., Louisville, received the Distinguished Alumni Award at the ninth annual University of Louisville Hospitals Alumni Association meeting June 7.

Doctor McCarty, retired internist, is the current president of the Southern Medical Association. The award was presented by Henry G. Saam, M.D., president of the Alumni Asscciation. The award program, which followed a daylong scientific session at General Hospital, was held at the Medical Arts Building.



AMA Holds 111th Annual Meeting in Chicago June 24-28

More than 30,000 persons, including 15,000 physicians were scheduled to attend sessions of the 111th annual meeting of the American Medical Association in Chicago June 24-28 as the Journal went to press.

This year's meeting, the first to be held in Chicago since 1956, emphasized mental health, nuclear medicine, and teenagers problems. In addition to lectures, symposiums, panels, roundtable luncheons, and evening fireside conferences, the program included medical motion pictures and a color television program.

Some 2000 medical scientists and educators participated in the meeting, which also included 700 scientific and industrial exhibits.

House of Delegates, policy-making body of the AMA convened at the Palmer House and were scheduled to announce the winner of the 1962 Distinguished Service Award and to elect a new president-elect.

On June 26, George M. Fister, M.D., Ogden, Utah, was installed as the 116th AMA president at inauguration ceremonies in the International Ballroom of the Conrad Hilton Hotel. Presidents of the 50 state medical societies, including Gaithel Simpson, M.D., Greenville, took part in the ceremony.

Featured at the 39th annual meeting of the AMA Woman's Auxiliary were addresses on "how to keep husbands healthy" and "what's new in national legislation." Sessions of the Auxiliary were held at the same time as the AMA meeting.

Complete coverage of the meeting will appear in the August Journal.

Scientific Consultants Appointed by Journal Editors

Names of eight new members of the Board of Consultants on Scientific Articles of the Journal of the KSMA were announced recently by Sam A. Overstreet, M.D., editor of the Journal.

Terms of the members of the Board became effective on July 1. The appointments were made by Doctor Overstreet and Associate Editor George Pedigo, M.D., Louisville, and members of the Advisory Committee to the Editor.

Appointed to serve until July 1, 1965 were: McHenry S. Brewer, M.D., Louisville; Lewis Dickinson, M.D., Glasgow; Zygmunt Gierlach, M.D., Lexington; Douglas L. Gillim, M.D., Louisville; Arthur H. Keeney, M.D., Louisville; James B. Stith, M.D., Lexington; Chester B. Theiss, M.D., Louisville; and Kearns R. Thompson, M.D., Lexington.

Doctors Overstreet and Pedigo expressed the Journal's appreciation for the excellent work of the retiring consultants during the past three years.

Those retiring after serving since July 1, 1959 are: Sam S. Clark, M.D., Louisville; Gene N. Combs, M.D., Pikeville; James T. Gilbert, Jr., M.D., Bowling Green; Albert E. Leggett, Jr., MD., Louisville; Owen Murphy, MD., Lexington; William E. Oldham, M.D., Louisville; Malcom D. Thompson, M.D., Louisville; and A. J. Whitehouse, M.D., Lexington.

Dr. McBeath Named Director of State Health Bureau

William H. McBeath, M.D., acting director of the Kentucky Health Department's Division of Medical Care, has been named director of the department's Bureau of Medical Services. The appointment, announced by Russell Teague, M.D., health commissioner, also makes McBeath director of the Division of Medical Care.



Dr. McBeath

Doctor McBeath, a graduate of the University of Louisville Medical School in 1957 with an M.D. degree, has been in Frankfort a year on loan from the U. S. Public Health Service. A native of Leitchfield, he is an instructor in the department of community medicine of the University of Kentucky's College of Medicine.

He will head the largest bureau in the Health Department. It has seven divisions—preventive medicine, tuberculosis control, veterinary public health, alcoholism control, hospital and medical facilities, chronic-disease control, and medical care.

College of Physicians Announces New Members, Fellows

During the past year the following Kentucky physicians have been elected to Associateship in the American College of Physicians, according to Sam A. Overstreet, M.D., Louisville, Governor for the Kentucky Chapter.

Jerome E. Cohn, M.D., Lexington
Charles N. Kavanaugh, Jr., M.D., Lexington
Daniel G. Lareau, M.D., Henderson
Leonard Leight, M.D., Louisville
John D. Lovett, M.D., Owensboro
Patrick I. McShane, M.D., McDowell
Milton F. Miller, M.D., Louisville
Bernard I. Popham, M.D., Louisville
Henry W. Post, M.D., Louisville
Melvin Shein, M.D., Louisville
Raymond J. Timmerman, M.D., Ft. Thomas
Lloyd G. Yopp, M.D., Louisville

The following have been advanced to Fellowship in the College:

Abraham M. Gordon, M.D., Louisville
Harold Clifford Morris, M.D., Louisville
Charles P. Orr, M.D., Paducah
David Willard Parsons, M.D., Madisonville
Richard C. Turrell, M.D., Louisville

The College held its 43rd Annual meeting in Philadelphia in April.

Doctor Bernhard Named To Head Ky. Surgical Society

C. Melvin Bernhard, M.D., Louisville, was elected president of the Kentucky Surgical Society at its 13th annual session at Cincinnati, May 25-26. Doctor Bernhard has served as secretary-treasurer of the Society for several years. He succeeds Clyde C. Sparks, M.D., Ashland, as president.



Doctor Bernhard

The new vice president of the Society is David A. Hull, M.D., Lexington, and the new secretary-treasurer is Blaine Lewis, M.D., Louisville.

Guest speaker at the meeting was Warren Cole, M.D., Chicago, professor and chairman of the Department of Surgery at the University of Illinois School of Medicine.

The Society will hold its 1963 meeting with the University of Kentucky College of Medicine at Lexington May 17-18. Ben Eiseman, M.D., professor and chairman of the U. of K. Department of Surgery, will cooperate in setting up the 1963 program.

New members taken into the Society at the 1962 session are: Winfrey P. Blackburn, M.D., Frankfort; William W. Johnson, M.D., and Giles M. Stephens, M.D., Louisville; Ben F. Eiseman, M.D.; Richard D. Floyd, M.D.; Ed Ray, Jr., M.D.; Frank C. Spencer, M.D., and Lucas N. Turk, III, M.D., all of Lexington.

AMA Summary Examines M.D.'s Selective Service Status

Through the Council on National Security, the American Medical Association has prepared a summary of the present status of Selective Service as it relates to physicians.

The summary points out that during 1961 three Selective Service calls for physicians were issued, the first time such calls have been necessary for several years; physicians called were among those in the youngest age group who had completed their internship and thus included almost exclusively first year residents and physicians just beginning private practice. Since the call was based on age, the summary says, it was not evenly distributed and some hospital-training programs suffered a depletion of their first year residents, while others were untouched.

In brief, to alleviate such conditions in the future the report urges that physicians, normally classified 1-A after completing their internship, may appeal the classification within 10 days by filing with the local board a written notice of appeal.

If a physician receives a Selective Service induction notice he may, if he is essential to his community or hospital and such can be documented, request a determination of such essentiality from his local or state board.

Physicians receiving induction notices may apply to the service in which commissioned for a delay because of essentiality or severe personal hardship.

Those not wishing to wait for draft may apply for reserve commissions under the Armed Forces Physicians Appointment and Residency Consideration Program with entry to active duty immediately upon completion of internship; as late as one year following internship or upon completion of residency training in specialties required by the armed forces.

King-Anderson Legislation Debated at Paducah

The proposed King-Anderson legislation was the subject for a televised three-quarters of an hour debate at Paducah May 27.

Opposing the proposed legislation which would place medical care for the aged under Social Security were Walter R. Johnson, M.D., Paducah, vice president (western) of the Kentucky State Medical Association, and Robert C. Long, M.D., Louisville, KSMA senior delegate to the American Medical Association.

Supporting the King-Anderson proposal were Hugh Owens, Paducah labor leader, and Sam Ezelle, Louisville, secretary of the AFL-CIO.

Medical men watching the show, which was televised locally, felt that the debate went well from the medical point of view.

Dr. Kinsman Gets New U of L Post; Appointments Made at UK

J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine will become a vice president of the University as soon as a new medical school dean can be found, according to an announcement by William McGlothlin, U of L vice president.



In his new position, Dr. Kinsman will be responsible for medical planning of new medical school facilities. He has been dean of the School of Medicine since 1948.

A committee headed by Rudolf Noer, M.D., chairman of the department of surgery, is seeking a new dean, McGlothin said.

University of Louisville is now seeking federal aid in building new medical and dental school quarters to replace old buildings, with tentative plans calling for expenditure of $8 million. As vice president Doctor Kinsman will head planning for new quarters, plus planning for participation in other grants which may be available.

An Atomic Energy Commission grant of $8,460 was recently awarded the department of surgery at the University of Kentucky College of Medicine.



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The grant will initiate or expand curricula relating to nuclear energy.

Eight new faculty appointments in departments of the U of K College of Medicine were announced recently.

Joining the department of surgery is Thomas C. Moore, M.D. Benjamin F. Rush, M.D., was appointed associate professor and Lester R. Bryant, M.D., was named an instructor of surgery.

Named to the department of pharmacology were Helmut Albert Gordon, M.D., as professor of Pharmacology; and Donald Diedrich, M.S., Ph.D., and James W. Flesher, M.S., Ph.D. as assistant professors of Pharmacology.

Henry Tesluk, M.D., will join the department of pathology with the rank of associate professor and James M. Whitehouse, M.S., Ph.D., will become assistant professor in the department of psychiatry.

Medical Complacency Is Topic of Doctor Bosworth

"Medical Complacency" was the title of the address presented by N. Lewis Bosworth, M.D., Lexington, before the Southeastern Sectional meeting of the Am. Urological Assoc. on April 8-12.

Doctor Bosworth said in part:

". . . we cannot afford to be oblivious to the inroads being made by dedicated individuals who are out to destroy the free enterprise system that has made this country of ours so great. These individuals began many years ago to undermine this great system and tagged medicine as their point of attack simply because they realized that physicians were not well organized and that the average doctor in practice was really too busy to do much about trying to stop their efforts. They also knew that doctors as a whole were not interested in politics, civic affairs and the like and that more than likely by the time they did awaken to what was actually going on, it would be too late. To be bluntly frank, their calculations have just about been right . . .

"We might ask ourselves, "How can we fight *the inevitable?*" First of all, I would tell you that we can no longer adhere strictly to political party lines but must actively support with deeds and money that man seeking office who is sympathetic to *our cause*.

"One of the ways that this is being done on state and national levels is through AMPAC and in my State, Kentucky, we have our organization called KEMPAC. These are permanent, voluntary, non-profit, non-partisan groups which we ,our wives and secretaries are urged to join. The annual dues are $20 for each individual, $10 of which goes to AMPAC and $10 kept in the State. The funds derived are to be used to support candidates running for office (be they Democrat, Republican or Independent) whose platforms are dedicated to the preservation of our free enterprise system, whether it be in the field of medicine or business.

"These funds will be used in target areas and support given to candidates after a study and realistic political appraisal has been made . . .

"Another way we can be effective is in educating the laity through our patients. We, as physicians, tend to underestimate the influence we have on our patients—the use of the waiting room by supplying it with the proper pamphlets and articles for reading by the patients will go a long way to get our point across to the public.

"Taking a few minutes of our time to talk with our patients about candidates, up-coming elections, pending legislative bills and the like and soliciting their support by means of votes and letters to Congressmen would produce results far beyond our expectations . . .

"Another source of strength from which the medical profession could draw and has been individually depending upon rather consistently, without actual awareness, is the doctor's wife. We all know what a powerful influence this good lady has on her respective household. Multiply this power by 10, 20, 30, 100 and so on, and organize and point in the right direction and you will find an amazingly effective force . . . . I would suggest the use of this auxiliary force to systematically contact friends, neighbors, etc., in letter-writing campaigns and even to organize into speaking groups to talk to the laity. It might well be that their main effectiveness would be to prod their husbands to greater interest in the affairs of organized medicine . . . .

"If we allow ourselves to become complacent we *cannot* and *should not* criticize what happens to the practice of medicine if the wrong policies are adopted."

Social Security Approach Opposed by Nurses

Members of the District 13 Nurses Association, meeting at the Clinton, Ky., Health Department, the week of May 20 passed a resolution opposing "medical care attached to Social Security benefits."

According to a story in the Ledger & Times, Murray, Ky., May 28, 1962, all members present at the session were opposed to the current legislation pending in Congress with the exception of one member.

The resolution passed by the Association read as follows:

"Whereas,

"We believe some form of medical care is needed to care for the indigent, we do not believe it should be attached to Social Security which would give medical care regardless of need and,

"Whereas,

"People can and should plan for their old age, we believe they will not do so if the government is going to do it for them, and,

"Whereas,

"The more laws that are passed requiring people to participate in any plan such as Social Security is gradually taking freedom away from the people and making them dependent on the government which will eventually destroy our democracy.

"Therefore be it resolved,

"That members of District 13 Nurses Association who are also members of Kentucky State Association of Registered Nurses and the ANA are opposed to medical care attached to Social Security benefits."

Digest of the Minutes of the KSMA Board of Trustees Meeting

May 20, 1962

Following the reports of the president and the headquarters office, the chairman explained the activities that would follow the meeting in connection with the dedication of the new headquarters office building that afternoon.

Keith P. Smith, M.D., Corbin, chairman of the Budget Committee, before presenting the proposed budget for the 1962-63 fiscal year, said that his committee had spent a full day working on the proposal and that it had been given lengthy consideration by the Executive Committee of the Board of Trustees which had recommended the proposed budget to the Board.

He explained that there were no large changes in the budget that was proposed for the 1962-63 year as compared to the one now in operation.

The budget, as approved by the Budget Committee and the Executive Committee, was approved by the Board with the exception of the postgraduate medical education program appropriation. The Board wanted more information before acting on this segment of the KSMA's activity and delayed acting on this until its July 26 meeting.

Doctor Smith then presented the recommendation of the Budget Committee with respect to the Association's overall financial position. He said the Budget Committee had considered the advantages of retiring the $100,000 debt on the new building during the year of 1963. He said if this could be done it would save the Association over $21,000 in interest over the next six years. He pointed out that the Budget Committee had found the total cost of the building greatly exceeded the original recommendations of the Building Committee due to the following facts: (1) the architects substantially underestimated construction costs, (2) two more lots had been purchased and (3) certain additions to the building were voted by the Board of Trustees after the original estimate was made. It was also noted that the Building Committee had recommended a 20-year ammortization of the debt, whereas the trustees had elected to pay it off in six years.

Following considerable discussion, it was decided to recommend to the House of Delegates that an assessment of $50 per member be voted for the year 1963 and that the proceeds from this would be used to pay off the debt on the building.

Other actions included accepting a recommendation of the Council on Medical Education and Hospitals to establish a committee on mental health. Where to hold the 1963 Interim Meeting (formerly County Society Officers Conference) was deferred until the July 26 meeting of the Board. A committee was appointed to purchase a lawnmower and the chairman of the Board of Trustees was authorized to nominate three members for consideration by the Governor to fill a vacancy that will develop on the Hospital Licensure Council July 1.

It was pointed out that the business community was protesting the fact that some physicians were supporting government ownership of industry as opposed to private ownership of industry. The Board, following discussion, voted to urge the KSMA membership to use its influence to forestall the socialization of private industry in Kentucky.

Leonard W. Larson, M.D., Bismarck, North Dakota, AMA president who attended the Board meeting and had been recognized earlier, briefly addressed the Board.

Dr. Crutcher Heads Ky. Heart Group

Richard R. Crutcher, M.D., Lexington was elected president of the Kentucky Heart Association at the 13th annual meeting at Louisville, June 7. Other KSMA members serving as officers of the group include: William R. Bushong, M.D., Tompkinsville, first vice president; George W. Pedigo, M.D., Louisville, vice president. Named to the board of directors was Walter S. Coe, M.D., Louisville; elected to the executive committee: Frank H. Moore, M.D., Bowling Green, and Morris M. Weiss, Sr., M.D., Louisville.

Industrial Medical Assn. Elects

New officers of the Kentucky Industrial Medical Association for 1962 are: Charles E. Allen, M.D., president; Frederick P. Shepherd, M.D., vice president; and Leslie Van Nostrand, M.D., secretary-treasurer. All are from Louisville.

Dr. McCarty Elected

A. Clayton McCarty, M.D., Louisville, has been elected chairman of the board of directors of the American Geriatrics Society. He was president of the Society during the past year and is also currently president of the Southern Medical Association.

Doctor McCarty has headed the Jefferson County Medical Society and has also been a vice president of the KSMA. He was chairman of the first committees on aging of both groups and has also long been active in other medical affairs.

AMA Selects Doctor Archer

George P. Archer, M.D., Prestonsburg, was appointed to service on the Reference Committee on Rules and Order of Business at the Annual Meeting of the House of Delegates of the American Medical Association in Chicago June 24-28. Doctor Archer is one of the three delegates of the Kentucky State Medical Association to the AMA and is also chairman of the board of directors of KEMPAC.



Receiving Civil Defense awards from Governor Bert T. Combs (third from left) at a meeting of the Campbell-Kenton Medical Society on May 16 are (left to right): Robert Reichert, M.D., Morris M. Garrett, M.D., and Donald Janney, M.D., all of Covington.

Combs Guest of Campbell-Kenton

Fifty-five members and their wives attended the annual dinner dance of the Campbell-Kenton County Medical Society on May 19 which had Governor Bert T. Combs as guest of honor.

Governor Combs presented awards to Doctors Robert Reichert, Morris M. Garrett, and Donald Janney for their outstanding work in local Civil Defense. Guests included: Judge Milliken of the Kentucky Court of Appeals and his wife; Bailey Root, area director of Civil Defense and his wife; Senator and Mrs. Lambert Hehl, Jr.; Representative and Mrs. Eugene Ostertag; and Representative Vernor Cottengim.

Ky. Ob.-Gyn. Society Elects

George G. Greene, M.D., Lexington, was installed as president of the Kentucky Obstetrical and Gynecological Society at the annual meeting May 24-26 at Owensboro. Doctor Greene succeeds W. H. Parker, M.D., Owensboro. Douglas Haynes, M.D., Louisville, was elected vice president of the group and J. B. Stith, M.D., Lexington, secretary-treasurer. Some 70 doctors, wives and nurses attended the 15th annual meeting of the Society.

Doctors-Lawyers Day Held

The first annual Doctor-Lawyers Day was held at Henderson May 24, according to the Henderson Gleaner & Journal. The day was highlighted with a dinner at the Country Club. Ralph Petrilli, professor of law at the University of Louisville, was guest speaker.

Beatty Resigns; Saliba Director

Oren A. Beatty, M.D., director of District Two State Tuberculosis Hospital (Hazelwood) for the past 11 years, left on July 1 to become medical director at Richland Hospital, Mansfield, Ohio. He will be succeeded as director by N. A. Saliba, M.D.

Doctor Saliba has been assistant medical director during the past year and has been with the hospital for the past 4 or 5 years. Doctor Beatty had been at the Richland hospital before coming to Hazelwood.

Project Starts at Central State

A three-year $42,000 grant from the National Institute of Mental Health has made possible a new project at Central State Hospital, Lakeland, aimed at preparing mental patients to adjust to community life. The project will begin in August and will test the use of social group processes in the rehabilitation of mentally ill persons. It will also provide an opportunity to develop and evaluate the skills of hospital staff members.

Teague Reappointed Health Chief

Russell Teague, M.D., veteran of 31 years in public-health work has been reappointed by the State Board of Health to another four-year term as health commissioner. After serving as director of several county health departments, he was appointed health commissioner in 1956.

Dr. Robertson on Centre Board

Robert W. Robertson, M.D., former KSMA president was recently elected to the Centre College Board of Trustees. He is one of three new trustees announced recently by the college.

OPPORTUNITIES

From The

KSMA Postgraduate Medical Education Office

Smith, Kline & French Make Gift

Smith, Kline & French, Philadelphia pharmaceutical firm, has made a grant of $300 to the Postgraduate Medical Education Office of the Kentucky State Medical Association for use in furthering the postgraduate educational program in Kentucky.

A recent ruling made the Kentucky Postgraduate Medical Education Fund exempt from the federal income tax, making contributions to it deductible by the donor. Gifts or transfers to the fund are deductible for federal estate and gift tax purposes.

In Kentucky

JULY

12	KAGP Seminar, Country Club, Paintsville, Ky.
19-20	KAGP Seminar, Kentucky Dam Village, Gilbertsville, Ky.

AUGUST

1	KAGP Seminar, Sue Bennett College, London, Ky.
9	KAGP Seminar, Bardstown, Ky.
19	KAGP Seminar, Lexington, Ky.
23	KAGP Seminar, Diamond Caverns Hotel, Park City, Ky.

SEPTEMBER

6	"Cardiovascular Surgery Course," U of K Medical Center, Lexington
18-20	KSMA Annual Meeting, Columbia Auditorium, Louisville

OCTOBER

3	Postgraduate Course—Anesthesiology Special emphasis for General Practitioners, General Hospital, Louisville, Ky.

Big Sandy Seminar Scheduled

The Big Sandy Seminar of the Kentucky Academy of General Practice will be held July 12 at the Paintsville Country Club beginning at noon. Chairmen of the Seminar are Allen B. Carter, M.D., Paul B. Hall, M.D., and Ernest G. Skaggs, M.D., all of Paintsville.

Guest speakers during the afternoon will be: Henry W. Post, M.D., Louisville, speaking on "Current Concepts of Hypertension;" Jerome Cohn, M.D., Lexington, who will discuss "Chronic Bronchitis and Pulmonary Emphysema;" Frank Falkner, M.D., presenting a discussion of "The Teen Ager;" and George Greene, M.D., Lexington, who will give a talk on "Personal Observation Ob-Gyn." The program has been submitted for four hours of Category I Credit.

Surrounding States

JULY

22	Symposium, *Inflammation, Mental Depression,* Blue Ridge Chapter of General Practice, Hotel Roanoke, Roanoke, Va.
23-27	Course in "Cardiopulmonary Problems in Children" sponsored by the Am. Coll. of Physicians, Edgewater Beach Hotel, Chicago.

AUGUST

23-25	West Virginia State Medical Association, White Sulphur Springs, W. Va.
29-30	Postgraduate Institute: Medical Aspects of High School Athletics, Ohio State University, Columbus, Ohio; advance registration only; write: Hart F. Page, OSMA, 79 E. St., Columbus, Ohio

SEPTEMBER

10-13	International College of Surgeons, New York, N. Y.
24 thru Oct. 6	PG Course in laryngology and bronchoesophygology, Univ. Illinois, College of Medicine, 1853 W. Polk St., Chicago 12

Is your group holding a meeting or sponsoring a speaker or an activity that you believe would interest others in the profession?

Are you looking for a speaker for your next monthly session or annual meeting?

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(equivalent to 2 ml. paregoric)

Warning: May be habit forming.

DOSAGE: **Adults**—Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children—½ teaspoon (=2.5 ml.) per 15 pounds of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 1 pint (raspberry flavor, pink color)*

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KSMA Council, Committee Reports

Committee to Study the Constitution and Bylaws

E. C. Strode, M.D., Lexington, Chairman

KSMA Headquarters Building **May 9, 1962**

The KSMA Committee to Study the Constitution and Bylaws considered referrals from the Board of Trustees and other sources.

Following a three and one-half hour meeting, the Committee agreed that the digest of the meeting would be the basis for its annual report to the House of Delegates.

Building Committee

G. F. Brockman, M.D., Greenville, Chairman

KSMA Headquarters Building **April 26, 1962**

At the April 26 meeting of the Building Committee a detailed tour of the KSMA Headquarters Building and the premises was made by the Committee and the architect.

Following this careful inspection of the property, the Committee considered unfinished matters relating to the operation of the building and approved final plans for the dedication.

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman

Brown Hotel, Louisville **May 9, 1962**

KSMA's Council on Legislative Activities and Committee of eight Congressional District key men met in Louisville May 9.

The group was particularly concerned as to the thinking of the AMA in regard to the status of the King-Anderson legislation and eager to have comments relative to the visit with President Kennedy.

To get this information a telephone hook-up was devised with the use of speakers and amplifiers whereby our group could have a room conference discussion with officials in AMA Headquarters.

The Council and Committee were told the American public is getting better informed on the King-Anderson Bill and that the directional trend is favorable to medicine. Spokesmen for the AMA emphasized the importance of sending letters, telegrams and resolutions to the writers' own Congressmen and Senators and to the Chairman of the House Ways and Means Committee. Also, personal contacts were encouraged.

The AFL-CIO-sponsored one-day speakers training institute to be held at the University of Louisville campus on May 12 was discussed. It was felt that representatives of the medical profession should be present at this open meeting.

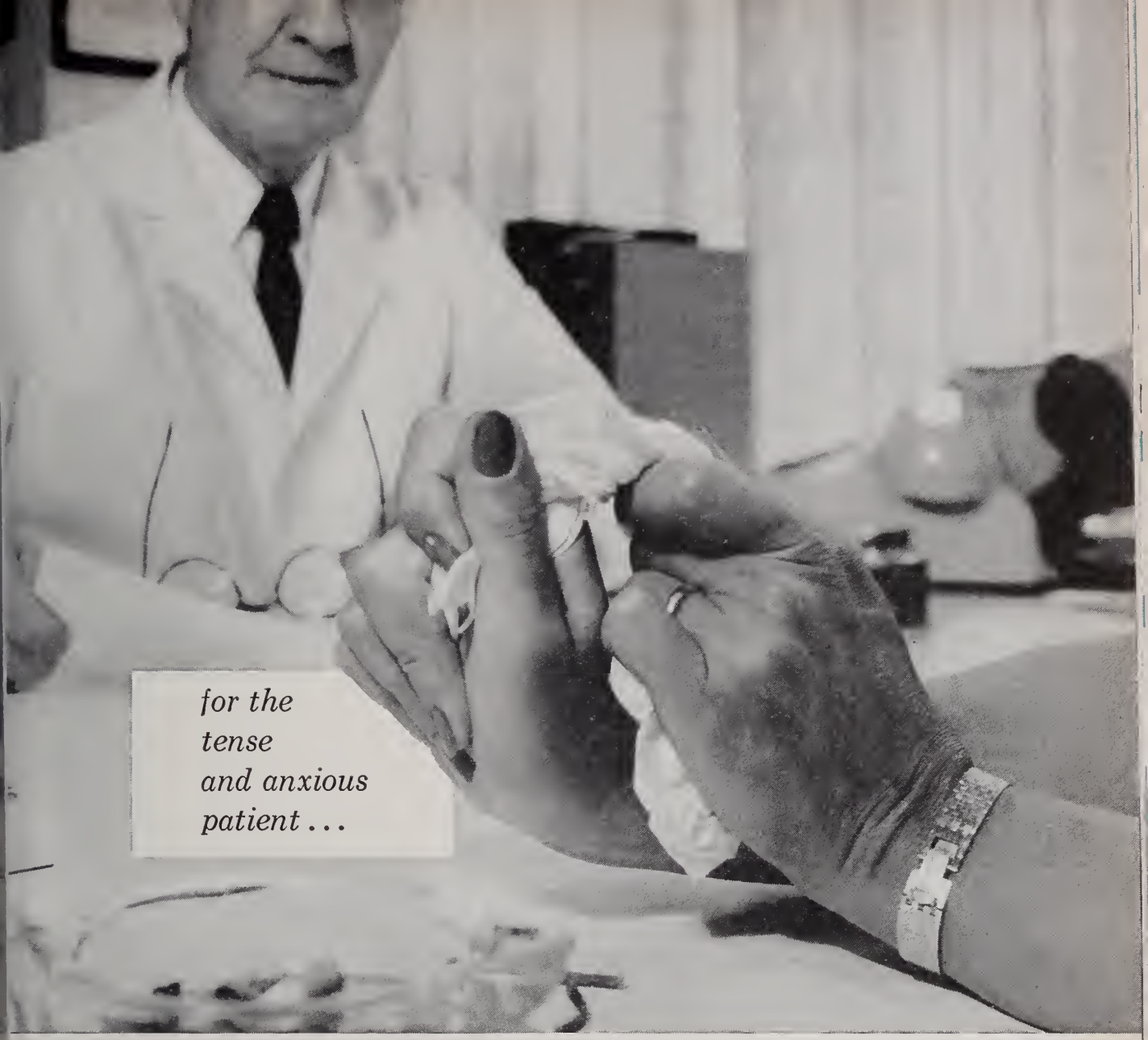
The May 20 Madison Square Garden spectacular for the aged and the Senior Citizens Convention of May 25-26 in Washington, D. C., received comments.

Mrs. G. David McClure, Louisville, KSMA's Auxiliary Legislative chairman, was commended for her work along with other Auxiliary members in their effective campaign against H.R. 4222.

Hoyt D. Gardner, M.D., Louisville, secretary-treasurer of KEMPAC, reported on the pogress of KEMPAC and told of plans to have candidates of both parties appear at meetings of the organization and give their views on medical issues.

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"Kentucky Business" Is Cited

The American Association of Commerce Publications has given *Kentucky Business* magazine an award for best editorial content among state chamber of commerce magazines. The magazine, official publication of the Kentucky Chamber of Commerce, was cited for "outstanding performance in promoting the well-being of business and the state" in 1961-62.

Doctor Kirk in Kentucky

Norris J. Kirk, M.D., F.A.C.S., Chicago, is spending three and one-half months in Kentucky making a survey of hospitals for the Joint Commission on Accreditation.

Doctor Kirk is here primarily to represent the American College of Surgeons and is making surveys of cancer programs in the hospitals of the State. The purpose of his visit is educational—to show hospitals and their staffs how their cancer programs can be made to qualify for approval by the College.

John W. Armstrong, M.D., director of the Student Health Service at Berea College and eye, nose and throat specialist at Berea, was honored at a dinner May 22. Doctor Armstrong is retiring in September. About 80 doctors, nurses and hospital personnel attended the dinner. Doctor Armstrong has completed 36 years of service at Berea College and is a former superintendent of the Berea College Hospital.

Fred D. Barlow, M.D., and **Russell F. Scalf, M.D.,** have opened an office at Louisville for the practice of radiology. Doctor Barlow was graduated from the University of Louisville School of Medicine in 1954; interned at Kentucky Baptist Hospital and did his residency work at the U. of L. Hospitals. Doctor Scalf was graduated from the U. of L. Medical School in 1953; interned at San Diego, Calif., County Hospital and served his residency at Louisville General Hospital. Both were previously associated with Sts. Mary and Elizabeth Hospital and will continue their hospital work along with their private practice.

N. B. Hasler, M.D., formerly of Louisville, has moved to Arlington, Mass., to take a position in the medical department of the Liberty Mutual Insurance Company. He will work in the New England area division. Doctor Hasler was with the medical department of the Commonwealth Life Insurance Company of Louisville for almost five years before resigning last October to work at the old Waverly Hills Hospital and Silvercrest Hospital in Indiana. He was active in tuberculosis association circles.

Edwin R. Davis, M.D., Owingsville, secretary of the Bath County Medical Society, has given up his general practice to take a residency in radiology. His practice at Owingsville has been taken over by Donald Cameron, M.D., Owenton. Doctor Davis was graduated from the University of Louisville School of Medicine in 1956.

V. A. Jackson, M.D., Clinton, Ky., surgeon, has moved to Lexington. Doctor Jackson was graduated from the University of Louisville School of Medicine in 1941.

William H. Marshall, M.D., Louisville, has opened an office for the practice of general surgery. Doctor Marshall was graduated from the University of Illinois School of Medicine in 1953 and served his internship and residency in University of Illinois hospitals. He served as a lieutenant in the Navy from 1955 to 1957.

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Phenacetin (3 gr.)	194 mg.
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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GENERAL PHYSICIAN FOR FULL-TIME APPOINTMENT VETERANS ADMINISTRATION HOSPITAL LEXINGTON, KENTUCKY

There is an opening for a full-time appointment at VA Hospital, Lexington, Kentucky, for a well-qualified general physician to head the Admission and Outpatient Service. U. S. citizenship, a state license and age not exceeding 54 are required. Starting salary is $7560 to $14,042 depending on qualifications, with regular pay increases. Liberal fringe benefits include retirement, vacation and sick leave, life insurance and hospitalization insurance. Interested applicants please contact—C. I. Schwartz, M.D., Chief of Staff, VA Hospital, Lexington, Kentucky for further information.

SPECIAL ARTICLE

(Continued from Page 670)

initiative, in support of a good cause or the defeat of one we oppose.

5. We must offer our financial help, to the best of our abilities, to the groups to which we belong, the political party in which we believe, the associations we feel are working to the betterment of the people.

That is all there is to good citizenship. But it can bring about the solution of a great many of the problems facing us today. It can make our nation greater, our states and cities more progressive. Best of all, when "taken internally," it can change a "Mr. Average" to a "Mr. Citizen."

New KSMA Members Listed

New members of KSMA since the last report in The Journal are:

Charles F. Blankenship, M.D., Louisville
Thomas R. Marshall, M.D., Louisville
Arthur McCurry, M.D., Middlesboro
Herman Wing, M.D., Louisville

Daniel J. Lareau, M.D., formerly of Henderson, Ky., has taken a position with the Veterans Hospital and the University of Kentucky Medical Center at Lexington.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



THIS 36-year-old white gravida 4, para 3 entered the hospital at 5:10 p.m. on May 7, 1960. She had been seen by a physician in another town, and he had sent her in as an emergency case. She was uncertain of her last menstrual period but remembered that her period in February had been abnormal.

She denied any symptoms of pregnancy. At various times in the past she had been subjected to uterine suspension, appendectomy and bilateral tubal ligation.

On admission, the patient complained of pain in the abdomen and back of two days' duration; the pain was described as constantly present, but with rhythmical variations in severity. The patient had noted some enlargement of the abdomen. For 24 hours prior to admission she had experienced nausea and vomiting.

She had been observed in the referring physician's clinic for about 10 hours before transfer, the presumptive diagnosis being premature labor. The sudden appearance of clinical signs of shock motivated her immediate removal to the hospital.

The patient seemed to be acutely ill on admission. The blood pressure was 136/66, the pulse, 128, and the temperature, 100.6°F. The abdomen showed generalized tenderness, more severe in the right upper quadrant and flank. Normal peristalsis was present, a pelvic mass was felt extending to one fingerbreadth below the umbilicus.

On pelvic examination, the abdominally palpable mass seemed globular and measured approximately 16x20 cm. in maximum diameters; it was thought to arise from the left adnexa. No bulging was noted in the cul-de-sac.

The initial clinical impression was that of acute internal hemorrhage, possibly secondary to a twisted ovarian cyst or an ectopic pregnancy. A glucose infusion was given intravenously while the patient's blood was typed and crossmatched. A 500 cc. whole blood transfusion was started at 7:30 p.m. At 8 p.m. the patient was given 150 mg. of declomycin together with 75 mg. of demerol for pain.

A second 500 cc. whole blood transfusion was given at 11 p.m. At midnight the temperature was 100.2°F., pulse, 102; respirations, 32. Later she awakened and complained of soreness. Her abdomen was very tender when touched and she appeared in distress when she breathed.

On Monday, May 9, the patient appeared dyspneic and her abdomen was distended. Levine tube suction was instituted and two 500 cc. whole blood transfusions were administered. Her condition was described as poor.

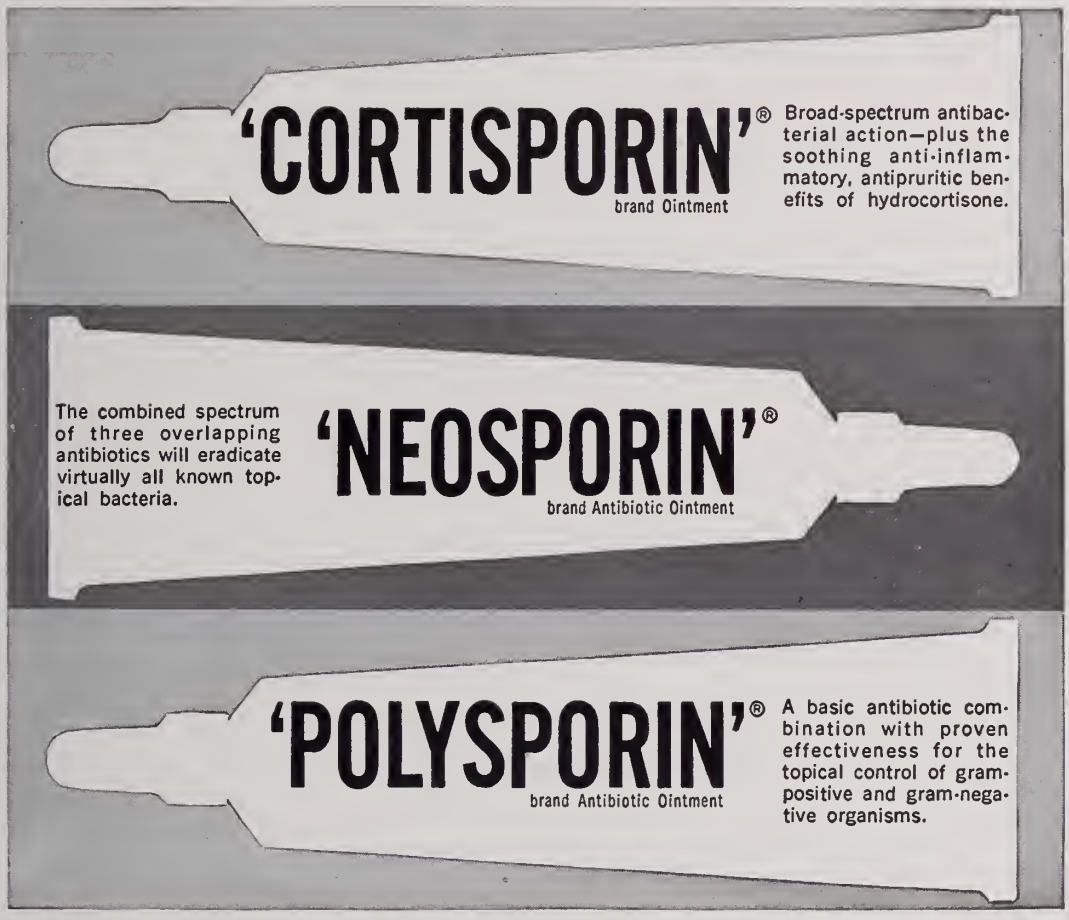
At this point it was decided to perform a laparotomy; this was done under general anesthesia, which was described as unsatisfactory, without further elaboration. The abdomen was found to contain about 1000 cc. of liquid and clotted blood. A fetus the size of a four-months' gestation was found free in the abdomen. Placental tissue was implanted on the right broad ligament, the sigmoid colon and the round ligament.

A left salpingo-oophorectomy was performed, with reasonably good control of the bleeding points. Gelfoam was placed on the oozing surfaces and the abdomen was closed. The patient left the operating room in very poor condition. The operation had been started at 4:42 p.m. and was completed at 5:27 p.m. At 5:40 p.m. the blood pressure was 110/65 and the pulse, 128. Another transfusion was given at 8 p.m. At 11:30 p.m. the blood pressure began to drop and this continued despite the administration of vasopressor drugs (vasoxyl, levophed). At 2:40 a.m. on May 10, 1960, the nailbeds were noted to be cyanotic. The patient died at 3:30 a.m.

Comments

The committee considered this to be a case of direct obstetric death with the strong preventable factor of undue delay in undertaking the exploratory operation. An earlier cul-de-sac examination would have clarified the diagnosis if it had been done. The case illustrates the diagnostic confusion which may arise when a patient has an erroneous impression of what was done at a previous surgical operation.

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PUBLIC HEALTH PAGE

Recommendations for the Use of Poliomyelitis Vaccines

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health

Commonwealth of Kentucky

WITH the licensing of TYPE III oral poliomyelitis vaccine, the United States takes another major step toward the final conquest of paralytic poliomyelitis. Now two effective weapons, the formaldehyde-inactivated vaccine and the oral vaccine, are available for general use. Their proper application should accelerate the decline in poliomyelitis and could lead to the early elimination of the disease.

The Salk vaccine was licensed in 1955. Since then it has been used extensively in this country and in many parts of the world. In all areas where its use has been widespread, great reductions in incidence of paralytic poliomyelitis have been observed.

In the United States, where over 400,000,000 doses have been administered, the decline in paralytic poliomyelitis has exceeded 90%. However, the vaccine has been used to varying extents in different population groups. Over 65% of preschool children and about 70% of young adults, particularly males, have not received the recommended series of four injections. Outbreaks, and even some severe epidemics, still occur. These have been confined largely to the unimmunized or incompletely inoculated groups, but sporadic cases of the paralytic form of the disease have continued to be reported among individuals who have had three and even four doses of the vaccine. Its widespread use continues to be recommended.

However, live oral vaccine offers several advantages over the killed vaccine and the following guidelines for its use may be helpful. The live oral vaccine is best used on a community-wide basis whenever an epidemic of poliomyelitis strikes an area and the specific type can be identified. In non-epidemic areas in the months immediately ahead, local circumstances plus the availability of vaccine will influence the methods of use.

Many communities may wish to undertake organized programs to raise the level of poliomyelitis immunity. The choice of vaccines rests with the physicians of a community, and, at least in the immediate future, will depend upon vaccine supply, organizational time table and community priorities in need.

The oral vaccine has a slight disadvantage in that there is a problem of preservation of the commercial product and the possible seasonal variation in its effectiveness. At the present time the oral vaccines must be stored in the frozen state. After thawing and dilution for use, the presently recommended shelf life is only one week. The disadvantage is slight in community-wide programs, but more significant for general office or clinic practice.

Enteric viruses may interfere with the effectiveness of the oral vaccine. Since these are more widely prevalent in the summer months, organized community wide immunization programs using oral vaccine are best undertaken during the late fall, winter and spring months of the year, except in the face of a threatened epidemic.

During the coming months when supplies of both oral and inactivated vaccines may be limited, the following priorities for use of the polio vaccine are recommended:

1. *Use in Epidemic Control.*

2. *Infants.* All communities should organize programs of polio immunization directed to the goal of completing the recommended immunization schedule for all infants by the time they reach their first birthday. Dosage schedules for the use of either vaccine are outlined in following sections.

3. *Preschool Children.* Effective programs should be organized to reach all preschool children not yet fully immunized. Completion of the schedule of formaldehyde-inactivated vaccine or initiation of a full course of the oral vaccines may be chosen.

4. *Other Unimmunized Groups.* Older population groups, particularly young adults and parents of small children, should continue to be encouraged to receive immunizations.

The following guidelines are, in general, based upon the February 1962 recommendations of Subcommittee One of the Advisory Committee on Poliomyelitis Control dealing specifically with the use of the oral vaccine:

(Continued on Page 705)

This article was prepared by Strawn W. Taylor, director, Bureau of Research, Planning and Development, Kentucky State Department of Health, Frankfort, Ky.



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IN THE BOOKS



EARLY DETECTION AND DIAGNOSIS OF CANCER: by Walter E. O'Donnell, M.D.; Emerson Day, M.D., F.A.C.P., and Louis Venet, M.D., F.A.C.S.; published by C. V. Mosby Company, St. Louis, Mo.; 286 pages; price, $12.

The opening two sentences of the preface accurately describe the book: "This book is a comprehensive, practical guide to the essential facts about most types of cancer—how to look for and diagnose cancer in the physician's office and what to do about it initially. It is not a definitive treatise or reference work on the subject of cancer and all its ramifications."

The authors state that, "The first physician to see the patient is unquestionably in the first line of defense against cancer." They urge every physician, regardless of his particular type of practice, to be on the look-out for premalignant lesions and cancer in its early stages.

Chapter II entitled, The Cancer Detection Examination, I believe to be the most important part of the book. Here they describe in some detail how to perform a cancer detection examination, *in the physician's office*. The rationale of cancer detection; the selection of patients for examination; the history, physical examination and laboratory procedures are all discussed in this most important chapter.

The remaining chapters are concerned with a particular organ system or area of the body. Each in turn is discussed from the standpoint of epidemiology, etiology, pathology, screening of asymptomatic patients, clinical features and steps in the diagnosis and initial management.

The book is written in semi-outline form. This, to me, does not make for enjoyable reading. It does, however, allow the authors to get a great deal of factual information in a small book.

Stuart Graves Jr., M.D.

CARCINOMA OF THE CERVIX: by John B. Graham, M.D.; Luciano S. J. Sotto, M.D., and Frank P. Paloucek, M.D.; published by W. B. Saunders Company, Philadelphia and London; 487 pages; price, $14.

This is an exceptionally well-written and lucid book. It covers succinctly nearly all aspects of carcinoma of cervix though the emphasis is upon treatment. The 28 chapters range from frequency of the disease, through causes, gross and microscopical appearances, natural history of the disease, diagnosis, staging, metastatic patterns, prognostic factors, management, radiation and surgical treatment, results and complications of treatment.

The authors substantiate most of their statements by tabular data taken from their own experience and that of others. They approach most of the statistics with reasonable skepticism and make allowances for many variables. This reviewer's principal complaint about the data is that many tables would be easier to interpret if a few statistical tests of significance had been reported.

The format and typography are pleasing; the illustrations well selected and well reproduced.

This book contains a mass of information, and the opinions of the authors are well presented.

The most disappointing chapters are those dealing with the results of treatment. Much progress has been made, but as the authors point out, "The results in treatment of cervical cancer are no cause for complacency."

W. B. Stewart, M.D.

Current Therapy, 1962, Latest Approved Methods of Treatment for the Practicing Physician; Howard F. Conn, editor; W. B. Saunders Company; Philadelphia and London, 1962.

The 14th annual edition of *CURRENT THERAPY* makes readily available to physicians concise and, in many instances, quite detailed guides to specific therapy in a very wide variety of clinical entities. It has and will prove particularly valuable as a ready source of reference in circumstances uncommonly encountered by the specific physician, especially if these situations require rapid therapeutic intervention.

This reviewer believes that the detailed information concerning poisoning which this volume contains constitutes the most valuable kind of reference material for any physician. There is a consideration of 130 common poisons and of their specific antidotes. There are also detailed lists of the poisonous substances in common household items and of the principal active ingredients in various commercial products; these lists are cross-indexed with the poison-antidote section.

The value of this annual could, in the opinion of this reviewer, be greatly enhanced, without any appreciable increase in its size, were each contributor to list 3-5 references to which the reader might go for further consideration of the particular problem at hand.

Paul Mandelstam, M.D.



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1. *Methyl-Testerone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No.2, February 1962, pp. 6-8.*
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Q. I performed surgery on a patient and the patient remained in the hospital for 45 days beyond the surgery date. I attended the patient throughout the stay. In addition to the surgery allowance would Blue Shield also make payment under the medical rider in this case?

A. Under the Blue Shield Medical Rider, hospital calls by operating physicians 10 days prior to surgery and 30 days following surgery are considered part of surgical procedure and no payment is made under the Medical Rider. Special consideration is given for necessary hospital care beyond 30 days following surgery.

In Memoriam

WILLIAM ROBERT PARKS, M.D.
Harlan
1896-1962

William Robert Parks, M.D., Harlan physician for 34 years, died May 22 at Roanoke Va., where he had been making his home since retiring from active practice at Harlan in April 1956. He suffered a stroke May 20.

Doctor Parks received his medical degree from the University of Louisville School of Medicine in 1922 and opened his office at Harlan for general practice that same year. Shortly after World War II Doctor Parks and Philip J. Begley, M.D., formed the Parks-Begley Clinic. Their association continued until Doctor Parks went into semi-retirement and moved to Roanoke. In that city he was associated with the Veterans Hospital and worked part-time.

Doctor Parks was a vice president of the Kentucky State Medical Association in 1940-41 and was a former president of the Harlan County Medical Society. He was active in medical association and civic affairs.

EDWARD PHILLIP WHISTLER, M.D.
Harrodsburg
1890-1962

Edward Phillip Whistler, M.D., 71, who had been in general practice at Harrodsburg for 25 years, died May 27 at Veterans Hospital, Louisville.

Doctor Whistler was head of the Jefferson County Health Department from 1925 to 1932. He was graduated from the University of Louisville School of Medicine in 1915. During World War I he was a Navy lieutenant. Doctor Whistler was a member of the American Medical Association and the Kentucky State Medical Association.

PUBLIC HEALTH PAGE
(Continued from Page 700)

1. It is recommended that the three types of oral vaccines be administered sequentially, each in monovalent form at intervals of about six weeks. Special efforts will be necessary to maintain a high level of community interest and public response to obtain the necessary coverage.

2. Optimally, large scale immunization campaigns with oral polio-virus vaccines should be conducted during the winter or spring months. This consideration, however, should not preclude initiation of such programs in communities that have been unable to obtain sufficient vaccine sooner.

These observations are all based on statements issued by the Surgeon General of the United States Public Health Service. If any further details are desired, physicians and other interested persons are welcome to inquire in the Office of the Commissioner, Kentucky State Department of Health.

ERNEST RAU, M.D.
Bowling Green
1874-1962

Ernest Rau, M.D., retired Bowling Green physician, who practiced medicine there for 53 years, died May 25 following a stroke on May 18 at City-County Hospital, Bowling Green.

Doctor Rau was a graduate of the Medical Department of the University of the South at Sewanee, Tenn. He worked with the late J. N. McCormack, M.D., and his son, the late Arthur T. McCormack, in organizing the State Board of Health which was located at Bowling Green for many years.

During World War 1, Doctor Rau served as a captain with the U. S. Medical Corps in France and later with the Army of Occupation in Germany.

ULYSSES H. SMITH
Louisville
1892 - 1962

Ulysses H. Smith, M.D., Louisville, a retired general practitioner and surgeon died June 14. Doctor Smith, a native of Phenix City, Ala., was a 1916 graduate of the University of Louisville Medical Department. He began practice in Bingham Canyon, Utah, and moved to Louisville in 1919 where he practiced until his retirement in 1949. He was 70.

Washington News
(Continued from Page 636)

The AMA opposed legislation that would permit beneficiaries of the Federal Employees' Compensation Act to utilize the services of chiropractors.

In a letter to the chairman of the Senate Subcommittee on Employees Compensation, Doctor Blasingame said:

"Chiropractic is a pseudo-science which is not based on scientific methods and, therefore, should be recognized as what it is—a theory of cultism. It is premised on the theory that human illness is all related to the spinal column. It holds that the nerves that emanate from the spinal cord become impinged or 'pinched' by the vertebrae, thereby causing malfunction and disease.

"As a result of this theory, chiropractors claim that disease and illness such as allergies, diabetes, heart trouble and tonsillitis, to name a few, can be cured by adjusting or manipulating the spinal column. Such a theory, of course, runs counter to the established facts of medical science. . .

"Chiropractors are not educated nor equipped by either background or training to diagnose human illness. This inability to render a diagnosis coupled with their pseudo-scientific method of treatment when taken into consideration in connection with their vociferous stand against life-saving vaccines and wonder drugs, preludes that any consideration be given them."

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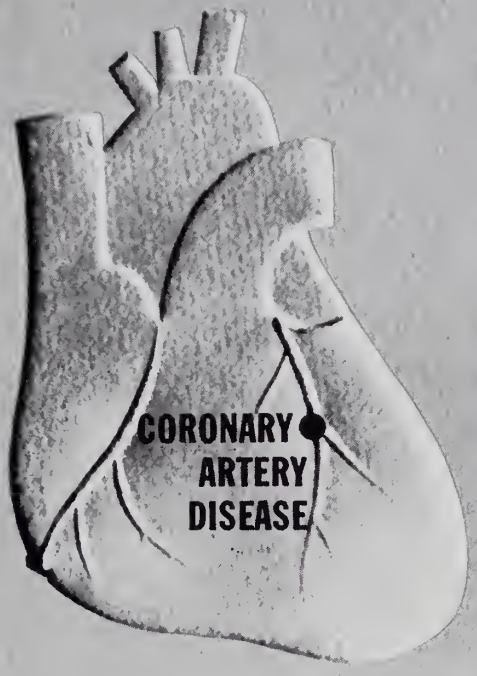
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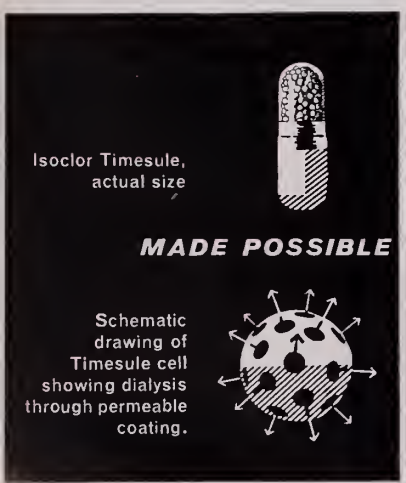
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The Clinical Session of KSMA – September 18 - 20, 1962

The KSMA offers many opportunities and advantages to its membership. The greatest, of course, is stimulation to keep abreast of progressive changes in the science of medicine. These are a few vehicles by which these matters are presented: The program of the Annual Clinical Session, The Journal of KSMA, and also the Post Graduate Training Program which is conducted in cooperation with other groups, etc.

Almost of equal importance, however, during the recent past are the programs of legislation which have been directed toward the protection of the practice of medicine in this nation as a free enterprise endeavor. These activities are organized on both state and federal level, and especially during the 1961-62 KSMA fiscal year, have been quite effective.

For these two and many other reasons let me urge you to attend the 1962 Annual Session in Louisville or offer to care for the patients of a confrere so that he may attend. This organization needs your support and you as a physician in Kentucky need its support and protection in these trying times.

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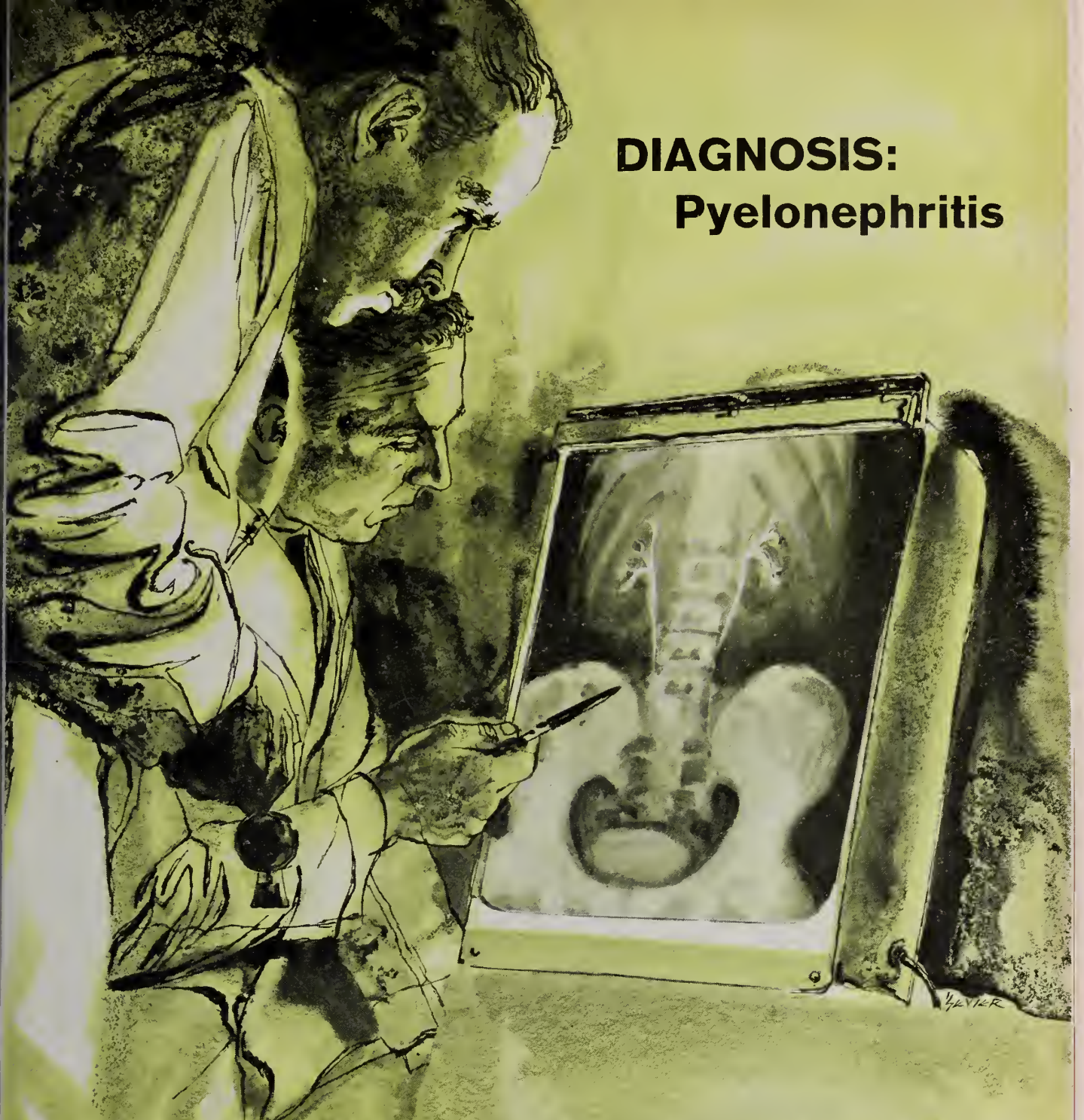
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WASHINGTON NEWS DIGEST



Washington, D. C.—The American Medical Association endorsed in principle the Kennedy Administration's proposed mass immunization program, but urged three important changes.

Dr. F. J. L. Blasingame, executive vice president of AMA, outlined the AMA's position in a letter to Rep. Oren Harris (D., Ark.), chairman of the House Commerce Committee which held hearings on the Administration legislation (H.R. 10541) Dr. Blasingame said:

"The American Medical Association endorses the principle of H. R. 10541 as applied to the four infectious diseases named in the bill—poliomyelitis, diphtheria, whooping cough and tetanus—but urges that: (1) the bill be limited to the four named diseases; (2) the bill be financed as a grant-in-aid program with the states participating on a matching formula basis; and (3) the programs be administered by State Health Departments, preserving the well-established and accepted relationships between the United States Public Health Service and the States in matters pertaining to health."

*** ***

The Committee accepted two of the changes proposed by the AMA—that the program be limited to the four specified diseases and administered by State Health Departments. The bill then was passed by the House and sent to the Senate where it promptly received approval of the Senate Labor and Public Welfare Committee.

The bill would authorize federal grants to states and their political subdivisions for "intensive community vaccination" programs against the four diseases during the next three fiscal years. It would authorize $14 million for grants in the first year of operation and $11 million annually for the following two years. The federal funds would be used to purchase vaccine for children under age five, and for salaries and related expenses of the state and local immunization programs.

"Our House of Delegates has on many occasions adopted policy resolutions urging immunization against polio, tetanus, and other communicable diseases for which vaccines exist," Dr. Blasingame said. "Although traditionally it has been the policy of the American Medical Association to urge that the best means of administering vaccines is in the doctor's office, with the family physician vaccinating his patients, we also have recognized that intensive immunization against communicable disease is a public health matter."

*** ***

The Public Health Service called on physicians to cooperate with community health officials and voluntary health agencies in launching in September a campaign to vaccinate pregnant women, persons suffering chronic debilitating diseases and the general population over age 45 against Asian influenza.

Surgeon General Luther L. Terry of the PHS urged that as many persons in these groups as possible be protected with one shot, or two if they are prescribed, before winter.

The call for the vaccination campaign was issued after a special advisory group warned that another wave of Asian influenza is due in the United States. The committee said that while accurate predictions are difficult, recent and past patterns of influenza A2 (known as the Asian strain) indicate it probably will occur throughout the nation this winter. The committee said indications were that influenza B would be infrequent.

The committee also recommended that serious consideration be given to immunizing persons in medical and health services, public safety, public utilities, transportation, education and communications fields. Dr. Terry said large scale immunization should be encouraged also in other industries and large institutions where absenteeism is of particular concern.

Previous campaigns included all persons over 65, but the age limit was lowered after study of past outbreaks.

Manufacturers of influenza vaccine were asked to estimate the amount of vaccine that would be needed and to have an adequate supply ready.

*** ***

The Federal Radiation Council said that indications are that radiation received by the average American from nuclear testing is "considerably less than the exposure from natural sources."

But, in a major policy statement, the Council conceded that there is little scientific data to back up this conclusion and that it is difficult to be precise in this field.

"While a considerable body of information has been accumulated on the effects of radiation on animals and man, the possible effects of low doses delivered at low dose rates are insufficiently known to permit firm conclusions about the extremely low exposures resulting from fallout," the Council said in a report, "Health Implications of Fallout from Nuclear Weapons Testing Through 1961."

"We cannot say with certainty what health hazards are caused by fallout from nuclear testing. We expect there will be some genetic effect; other effects such as leukemia and cancer are more speculative and may not occur at all. We can observe that, compared to the number of these same adverse biological effects occurring wholly apart from testing, the additional cases that might be caused by testing are a very small quantity. We conclude that nuclear testing through

(Continued on Page 796)

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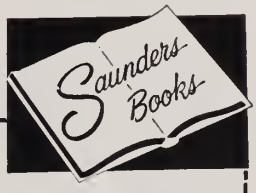
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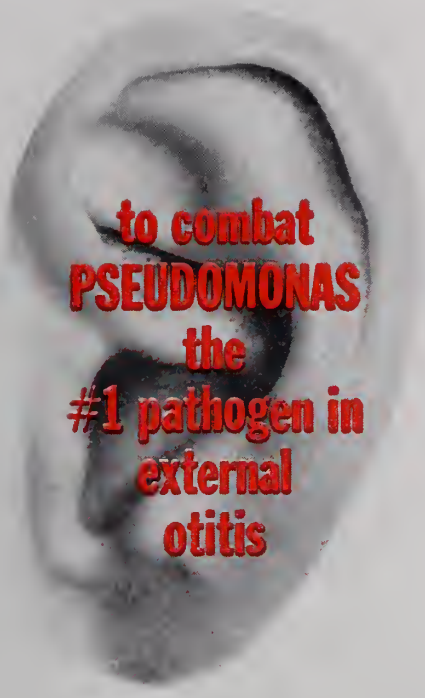
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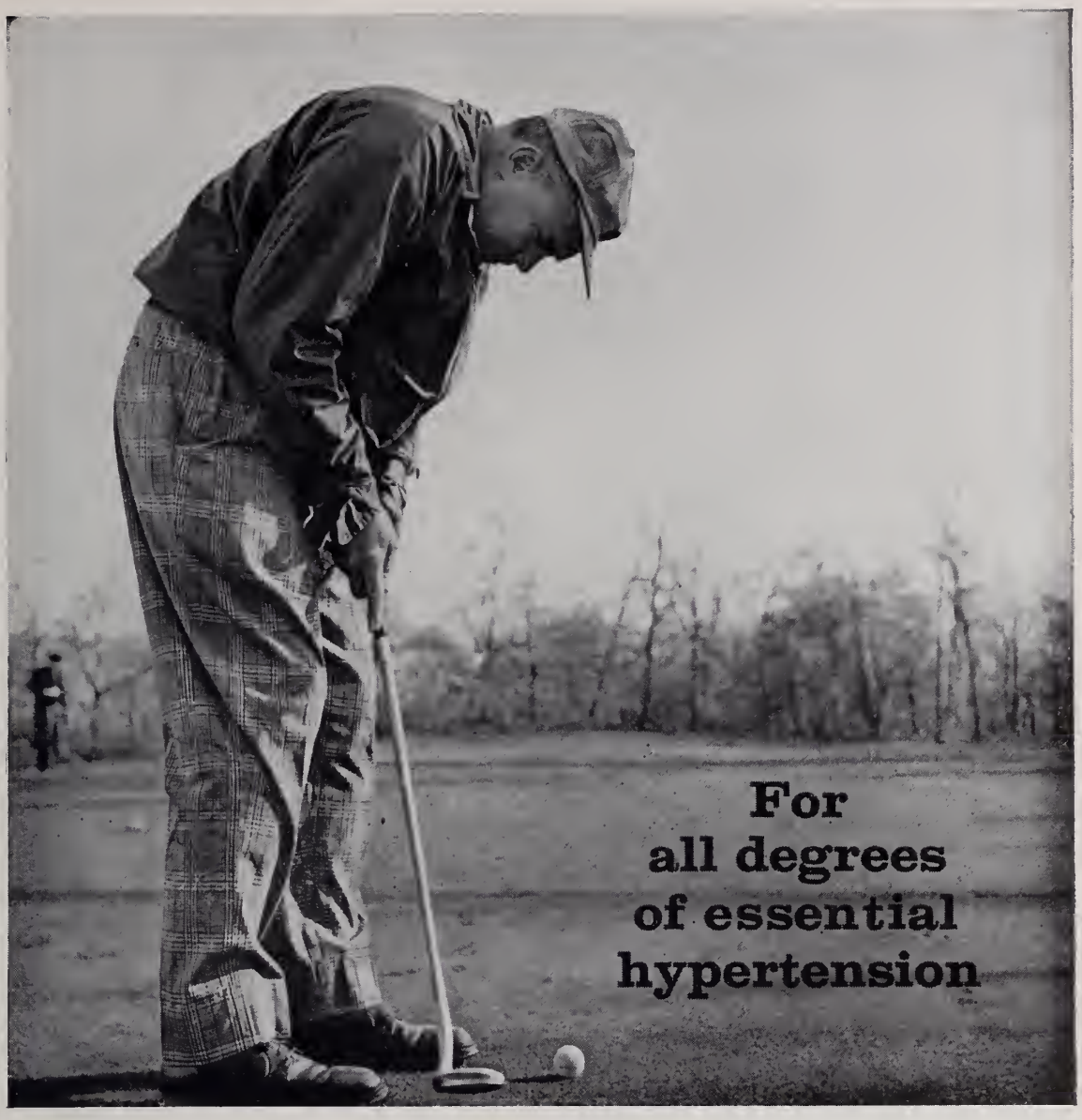
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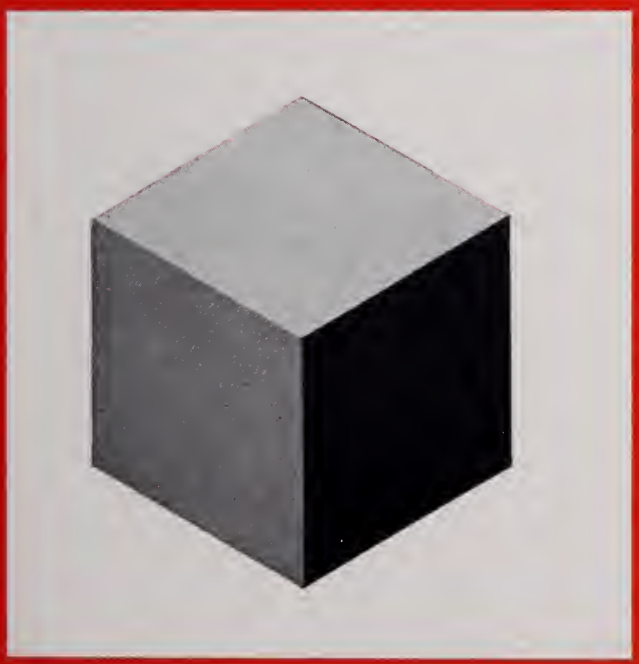
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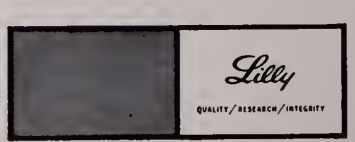
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Critical Evaluation of Tranquilizers*

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Louisville, Ky.

Drugs research reports, which today are many and varied, must be evaluated by the physician for his daily practice needs. Claims of success for the tranquilizers should be carefully appraised.

I AM not here to speak for or against tranquilizers. I do, however, want to stimulate your thinking in regard to these drugs so that you will utilize them more adequately and with better judgment. I hasten to add that pharmacological preparations are not the only answer for the various neurotic disorders. Again, let me say that I would like to look at the facts with you, as I see them, and thereby help you to make your own decisions.

There has been considerable publicity in regard to drugs in recent months. Some of this publicity is because of the Kefauver Committee investigation. As has been shown by this investigation and as you know much of our education about drugs comes from the various promotional programs of these drugs by the manufacturing companies. All too frequently the majority of physicians get their first, and often only, information about newly available drugs from these sources. This information is often prejudicial and frequently unreliable and misleading. The tranquilizing drugs have received much of their impetus from this type program.

I will discuss the problems involved when a patient takes tranquilizers in an effort to relieve anxiety, especially in contradistinction to the use of tranquilizers for the psychoses or borderline psychoses. There is no question in my mind but what tranquilizers for the psychoses are very important and are of great help. However, even this is being questioned by diligent, careful researchers. Since we wish to look at the use of tranquilizers for other than the psychoses, let me not belabor this point further.

A psychiatrist daily sees many patients with neuroses. Some of these are the type that the internist, or any physician, carries in his daily practice. My experience in the use of tranquilizers for the neuroses over a number of years has given me some opinion of their value and I have bolstered my opinions with the literature, attendance at meetings and research seminars and courses on pharmacology and drug therapy.

Classification

Since the mode of action is not entirely clear, some investigators have classified these drugs according to chemical similarity, as, the phenothiazines or the rauwolfia alkaloids, at the same time differentiating between substances with a

*Presented at Kentucky-Tennessee Regional Meeting of the American College of Physicians, November 18, 1961.

predominantly sedative action. Others have based a classification on mode of action. The latter seems the better for our purposes.

Table No. 1 lists some of the drugs which demobilize the defenses. They produce a fall in nervous or neurovegetative tension and cause a diminution in psychological tension accompanied by clinical relaxation. Hypnotics, such as barbiturates, could be included in this group. The neuroleptics produce psychomotor inhibition, modify changes in the neurovegetative system, disturb tonus, cause extrapyramidal effects and reduce psychotic manifestations. Finally, the tranquilizers, which have a sedative action on anxiety, do not produce the neurologic syndrome outlined above and do not materially influence psychotic processes. The neuroleptics and tranquilizers will be referred to as one large group, unless otherwise indicated.

III Effects

What happens to a patient on tranquilizing medication? Some schools of psychiatry emphasize that such medication will help the patient to discuss his problems and difficulties; in other words, psychotherapy supposedly progresses better. This possibly is true in some instances, but frequently it is not at all helpful. An additional problem may be created in that the patient is actually somewhat toned down and not really interested, doesn't strive to help himself, avoids problems and fails to cope with his difficulties as they arise. In fact, he uses the medication, if it is effective, as a "modus operandi"; he does not return and continues to take the drug over a period of time; his symptoms are cleared only to return later or to appear in some new area where anxiety finds means of expression.

Briefly, these drugs are inclined to be a problem in the course of administration in one or more of the following ways. First, these patients tend to have various and sundry difficulties. Second, they develop rather severe underlying problems and disorders of personality over a long period of time. Third, the patient experiences a relief of symptoms by taking medication; therefore, he will relate these facts and overidentify the meaning or be apt to wrongly interpret these meanings. Fourth, if the symptoms are relieved he is inclined to make no effort to try to find out the real causative factors. Fifth, tranquilizers create a false sense of security in the patient as well as in the physician. Sixth, the physician is inclined to want to cure everybody and relieve all symp-

TABLE NO. 1

Psycholeptics (Neuroleptics and Tranquilizers)

I. The Neuroleptics

Generic Name		Trade Names
(a) Phenothiazine Derivatives		
Chlorpromazine	*	Thorazine, Largactil, Megaphen, Aminazin
Mepazine		Pacatal, Pecazine, Lacumin
Promazine	*	
Trifluopromazine	*	Sparinè, Liranol, Verophen
Acepromazine	*	Vesprin, Vespral
Methoxypromazine	*	Plegicil, Notensil
Perphenazine	*	Tentone, Mopazine
Prochlorperazine	*	Trilafon, Fentazin
Trifluoperazine	*	Compazine, Stemetil, Nipodal
Thiopropazate	*	Stelazine
Methotrimeprazine	*	Dartal, Dartalan Laevopromazine, Veractil, Neurocil, Nozinan
Promethazine	*	Phenergan
Trimeprazine	*	Temaril
Fluphenazine	*	Permitil, Prolixin, Moditen, Antensol
Piperidinochlor phenothiazine	*	
Thioridazine	*	Mellaril
Thioproperazine	*	
(b) Rauwolfia Alkaloids		
Reserpine	*	Serpasil
Deserpidine	*	Harmonyl
Rescinnamine	*	Moderil
Rauwolfia Serpentina	*	Raudixin, Rauviloid
Syrosingopine	*	Singoserp
(c) Other Neuroleptics		
Tetrabenazine		Nitoman
Haloperidol		

II. Tranquilizers (Mild Non-Barbiturate Sedatives)

Generic Name		Trade Names
(a) Substituted Diols		
Meprobamate	*	Miltown, Equanil
Phenaglycodol	*	Ultran
(b) Diphenylmethane Derivatives		
Azacyclonal	*	Frenquel
Benactyzine	*	Suavitil, Phobex
Hydroxyzine	*	Atarax, Vistaril
Phenyltoloxamine	*	PRN
(c) Others		
Methylpentynol carbamate	*	Oblivon
Myanesin, Mephenesin	*	Tolserol
Ethylcrotonylurea	*	Nostyn, Levanil
Captodiamine	*	Suvren, Covatin
Buclicine	*	Softran, Vibazine
Methaminodiazepoxide	*	Librium
Oxonamide	*	Quiactin
Chlorothioxanthene	*	Taractan
Trimegamide		
Cyclohexalamine		

toms; therefore, he is always hoping that "this new drug" will be the "magic potion." Seventh, some of these drugs are habit-forming and addictive.

Placebos

In Table No. 1 note the asterisks indicating the drugs which have been reported extensively in the literature to be effective in the neuroses. Keep this in mind as we now consider some of the results of research in the use of placebos.

Experience with double-blind studies in the use of placebos has demonstrated the importance of this procedure. Investigators must conduct placebo control studies of new drugs in order to establish their value. We are not questioning the honesty of the patient or the integrity of the physician when we require placebos in the evaluations. Recent studies have shown that placebos have a remarkable potency. Table No. 2, taken from Beecher[2], reports concerning fifteen separate published studies by different authors and covering more than a thousand patients in whom the evaluations of the drugs depend upon subjective responses; in these the use of placebos gave relief in an average of 35% of the cases. The reports indicate that even in the relief of severe postoperative wound pain the placebo proved half as effective as morphine, and it appeared that the placebo was increasingly effective with increasing stress. Careful research has been done on the effects of placebos under many varied conditions. Gruber (Table No. 3) reports on one such condition, describing eleven patients on a clinical research ward, who were essentially well, volunteering for study of sedatives and stimulants. This study indicates that certain patients do what is expected of them, others are apt to be variable reactors, and still others respond in a manner opposite to that expected. None of the patients were placebo immune.

TABLE No. 2

Drugs which depend upon subjective responses

1. Sedatives	9. Euphoretics
2. Hypnotics	10. Depressants
3. Analgesics	11. Tranquilizers
4. Anesthetics	12. Aphrodisiacs
5. Antiemetics	13. Many endocrine products
6. Antitussives	
7. Anorectics	14. Tonics
8. Antipruritics	15. Muscle relaxants

TABLE No. 3

A study comparing two placebos

	Red Placebo ("Sedative") Night's Sleep		White Placebo ("Stimulant") Night's Sleep	
Patient	Good	Poor	Good	Poor
1	5	0	1	4
2	4	1	0	5
3	4	1	2	3
4	3	2	3	2
5	3	2	3	2
6	3	2	3	2
7	3	2	2	3
8	3	2	2	3
9	1	4	3	2
10	1	4	4	1
11	1	4	4	1

Another study by Gruber,[3] summarized in Table No. 4, indicates that a double dose of placebos is almost twice as good as a single dose in producing a night's sleep. Note too that, if a placebo produces toxic effects, one will find frequently that the placebo toxicity is increased when two placebos are used instead of one. These results are in terms of sedative placebos, from which patients experience hangovers, headaches, heartburn or restlessness. Kerr,[4] in a double-blind study of three preparations of oral iron versus a lactose placebo given to

TABLE No. 4

Patients' estimates of the effects of three sedatives at two dose levels

Drug	Chloral		"Valmid"		Placebo	
Number of Tablets	1*	2**	1*	2**	1	2
Sleep:						
Good	15	22***	17	28	10	21
Intermediate	2	3	1	2	5	4
Poor	2	1	1	2	4	7
Toxicity next morning:						
"Hungover"	6	7	2	7	3	8
Headache	8	6	3	3	2	5
Heartburn	2	2	1	2	0	3
Restlessness	2	7	0	4	1	11

*250 mg.
**500 mg.
***Underlined numbers are those of special interest.

student nurses, revealed that side effects usually attributed to oral iron were seen as frequently as 20% in the placebo group. As shown in Table No. 5, Lasagna[5] noted in most of the studies conducted on the use of placebos that

TABLE No. 5
The Placebo Reactor

Selected Items of Difference	% of Patients Giving Response	
	Reactors*	Non-Reactors**
Minimized the pain	72	19
Cooperative (nurse's report)	81	50
Likes "everyone"	54	12
Hospital "wonderful"	100	25
"Bad" menstrual pain	71	25
Frequent use of aspirin	45	12
Church goer	100	44
Years education	8.7	10.6
"Insides" response (Rorschach)	80	18
Maturity	less	more
Anxiety	more	less
Dependent upon outside stimulation	more	less
Rigidity—self-controlled	less	more
Intelligence and sex	— — Same — —	

*11 patients
**16 patients

the placebo responders are more pleasant, talkative, sociable, cooperative, and dependent upon outside stimulation. The non-responders are more mature, critical, independent, and less anxious. Sex was not a variable. It would appear that the placebo can never be used to distinguish real from imaginary pain or other subjective complaint.

For an example of the problem in the study of the placebo versus a drug, let me call your attention to one of the few well-controlled trials of muscle-relaxant drugs by Denhoff and Holden.[6] This is a study that has been maintained since 1955 in evaluation of mephenesin, chlorpromazine, reserpine, zoxazolamine, carisoprodol and emylcamate for the treatment of spasticity associated with cerebral palsy. Each of these drugs has been matched with a placebo and comparisons made in groups of children studied for neuromuscular function as well as general behavior. Beneficial effects on neuromuscular function ranged from 9% with reserpine to 56% with mephenesin; the mean was 33%. With placebo the improvement varied from 26% to 50%, and the mean was 39%. Favorable effects on behavior ranged from 8% with mephenesin to 53% with zoxazolamine, with a mean of 37%. With placebo behavior ratings improved by 17% to 80%, and the mean improvement was 46%. We cannot help but agree with the authors that the placebo had a greater "effectiveness" in the categories that were evaluated.

Evaluation of Literature

If we now look to the literature, we are impressed that certain writers seem to find excellent results with almost every drug they use, while other writers as frequently find poor results with these same drugs. The factor most often lacking is the control.

Meprobamate is probably the drug most often prescribed for anxiety and tension in the patient seen in the doctor's office. Let us make a critical evaluation of this drug. Most of the studies until 1959 were poorly conducted and thus unreliable. More recent studies are available. Let us look at unselected samples of several reports.

One of the favorable studies by Rickels[7] found meprobamate to be superior to amobarbital in neurotic outpatients. As has been noted by others, the opposite effect was indicated in an earlier controlled study by Raymond[8], who found that amobarbital was superior to meprobamate. In both studies the dosage of meprobamate was 400 mg. four times a day. The total daily dosage of amobarbital was 300 mg. in the Raymond study but only 120 mg. in the later Rickels study. There was no essential difference in the number and kind of side effects between amobarbital and meprobamate, in spite of the use of larger doses of amobarbital by Raymond. Even in a double-blind trial comparisons have little significance unless optimum dosages are used; therefore the results found with the low dosage of amobarbital in the Rickels study must be re-evaluated.

In a controlled study by Uhlenhuth[9], 400 mg. doses of meprobamate taken four times a day were found to be superior to a placebo in neurotic outpatients. However, this was found to be no better than 16 mg. phenobarbital taken four times a day.

The evidence of various controlled studies on meprobamate brings out many conflicting factors. Nevertheless, in the studies available in the literature, including both the new data and the data of early reports, I have not found convincing evidence that meprobamate offers any distinct advantage over adequate doses of

the barbiturates, either as a hypnotic or as a sedative for the relief of neurotic anxiety or tension.

Since Librium® has been given such glowing reports and acceptance recently, a great many physicians are using this drug for a variety of symptoms. One can find enthusiastic reports on Librium for use as an anticonvulsant, an aid in paraplegia, a support in alcoholism, an appetite stimulant, a muscle relaxant, an antidepressant, and a means to reduce anxiety. Indeed, according to several articles, angina, hypertension, and postmyocardial infarction are favorably modified by L i b r i u m as an adjunct in therapy. Again, as mentioned before, poor control was evident in these reports. In the report by Mooney[10] we can see that it is no better than other drugs available. A summation of the varied reports would indicate that Librium may turn out to be a useful addition to the group of tranquilizing drugs. From the preliminary uncontrolled studies we cannot but conclude that Librium appears to reduce anxiety and tension in some patients; whether it is more effective and consistent in its action that a barbiturate is unknown. Librium does not qualify as a true tranquilizer, since in the reported studies a significant number of patients show drowsiness or impairment of thinking processes as side effects.

If you check the literature of recent months, you will be impressed with the trend toward seeking the opinions of the internists and other specialists in evaluations of tranquilizing drugs. This, of course, brings in more diverse areas of investigation, and at the same time there are more complicating factors to influence results; so we must be more suspicious of the investigations, results and conclusions drawn. In view of these facts I remind you of something that we all know but tend to disregard: "There is a high rate of remission in psychoneurotic patients, especially when they are under doctor's care and receiving therapy of any kind. There is great difficulty in judging the degree of improvement in patients generally and especially those with neuroses. Therefore, physicians should not accept any but rigidly controlled studies as proof of successful treatment of neurotic or psychosomatic disorders."

Compazine® is another drug that has wide acceptance in office practice. It is unquestionably effective in agitated psychotic patients, but for the type of anxiety and tension seen in office practice, the outlook is not the same. Again, many uncontrolled studies present themselves, making this drug difficult to evaluate. It appears that when symptoms are severe and disabling and when other sedatives have failed, there is enough evidence to make Compazine worth trying. It should be used only as a temporary adjunct and withdrawn periodically for re-evaluation. It is especially noted as a potent antiemetic. It must be mentioned that there is a high incidence of undesirable neurological reactions, which are not due to toxicity but are associated with the cerebral action of the drug. These extrapyramidal manifestations, especially restlessness and akathisia, are easily reversible but at times are mistaken for evidence of extreme tension. I certainly w o u l d not recommend Compazine in perference to the usual sedatives in the common anxiety states or for any type of mild emotional disorder.

Deprol® is another drug that has been notable for its acceptance rather than its effectiveness. I include this drug because it is supposed to be effective in both neurotic and psychotic depressions. There is no convincing evidence that either of the two ingredients have any antidepressing properties. No doubt, since many depressions run a short c o u r s e and clear spontaneously, this improvement has been attributed to Deprol.

Recommendations

We have discussed the problems associated with the evaluation and use of the tranquilizers generally and several of the drugs specifically. Now, by way of conclusion, I would like to make some recommendations concerning tranquilizers.

While it is not always easy to locate the cause of disease, we must at least try. For instance, we do not give codeine for cough and ignore the cause, nor do we give aspirin for fever without at least trying to determine the site and cause of possible infection. So, rather than treat anxiety and tension as though it were the basis for the disease, we should try to find the cause of anxiety. Many patients who are anxious and tense and appear to have a neurosis actually have an underlying paranoid or schizoid personality. At times an illness of

this type appears as a depression. If you have doubts as to the presenting symptoms of these disorders, it would not take you long to check them in any standard psychiatric text. Such patients are helped most with one of the phenothiazines; Stelazine® is especially worth trying.

Tranquilizers are generally not effective in the simple mild anxiety states, nor are they effective in the obsessive-compulsive reactions. If they seem to help, it is only an expensive way to do what barbiturates would do as effectively, or better at a fraction of the cost. Since the latter disease is generally long-term and recurrent, the cost of medicine becomes quite important. Any severe and disabling neurosis will respond poorly, if at all, to any effort devoted only to relieving anxiety and tension.

Finally, let me encourage you to rely on well-documented research reports for your decision as to the efficacy of a drug. Be sure the articles show good control studies. Whenever you read an article that is reporting large percentages of cures or recoveries, be very suspicious and evaluate it very carefully. Don't let your enthusiastic desire to help your patient cloud your good judgment.

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Extracardiac Congenital Heart Disease*

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Congenital vascular ring, patent ductus arteriosus, and coarctation of the aorta are three common extracardiac congenital heart conditions which may endanger the life of a child. These abnormalities are discussed from the standpoint of their functional significance, altered cardiovascular dynamics, diagnosis and surgical treatment.

THE era of open heart surgery has focused attention on the dramatic features of intracardiac abnormalities almost to the exclusion of the equally important extracardiac abnormalities. Most of these extracardiac congenital anomalies can be treated without complicated machinery or large cardiovascular teams. They, nevertheless, constitute serious abnormalities which may endanger the life of the child in the neonatal period or in later years. This discussion concerns itself with three of the more common forms of extracardiac congenital heart disease.

Vascular Rings

The rarest of the three conditions under consideration, but one which may present as an emergency in the first few hours of life, is the congenital vascular ring. In this condition there is a complete arterial circle about the trachea and esophagus. Embryologically, this defect represents a failure of disappearance of certain portions of the normal branchial arches. In early fetal life six vascular arches surround the cephalic end of the esophagus and the trachea. These eventually result in the formation of the two great vessels, the aorta and the pulmonary artery, as well as the subclavian arteries and the carotid arterial system. In this process of reorganization, there is normally a disappearance of the complete vascular ring at each arch level. If this fails to occur, the child may be born with a vascular girdle squeezing the structures which lie within it.

The symptomatology is directly related to the degree of obstruction which the vascular ring produces. There are many patients with vascular rings who have no symptoms but have the abnormality discovered in the course of routine x-ray examinations. If there is marked constriction, however, the newborn infant may be in immediate distress either from tracheal or from esophageal compression or both. The diagnosis is dependent upon a high index of suspicion toward any newborn infant with respiratory distress or difficulty in feeding. Continuous or recurrent stridorous breathing, frequent choking, aspiration, profuse oral secretions, or inability to swallow should all suggest the possibility of some type of constricting vascular ring. The definitive diagnosis is made by instilling a water soluble contrast medium into the trachea or esophagus and demonstrating the marked indentation or area of obstruction.

The surgical treatment of this condition is interruption of the vascular ring. This is often complicated because most of these patients are very small infants who already have considerable respiratory difficulty and indeed may have varying degrees of aspiration pneumonia. The anesthesia problems are far more serious than are the operative problems. The usual approach is through a left thoracotomy, preferably in the anterior second or third intercostal space. The first step is careful mobilization of the arch

From the Department of Surgery, University of Louisville School of Medicine. Presented at the Cardiovascular Symposium of the Kentucky Academy of General Practice, January 18, 1962 in Cincinnati, Ohio.

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vessels and complete visualization of the abnormality. There are many varients of the congenital vascular ring but among the more common are the double aortic arch, the anterior left subclavian artery, and the short patent ductus arteriosus or ligamentum arteriosum associated with a right aortic arch. As soon as the abnormality has been visualized, the vascular ring is interrupted at an appropriate spot, care being taken to release the vascular attachments from the enclosed trachea and esophagus. Occasionally there are associated anomalies of the tracheal rings or of the esophageal wall. In these cases, relief of the vascular constriction alone will not result in a completely normal trachea or esophagus. Fortunately, in most cases there are no other associated anomalies and adequate release of the vascular constriction results in a normal trachea and esophagus with an excellent prognosis.

Patent Ductus Arteriosus

A second extracardiac congenital heart abnormality is the patent ductus arteriosus. This fetal structure is a normal component of intra-uterine development. It is thought to be an important means by which the oxygenated placental blood is short-circuited past the lungs in the fetal circulation and delivered directly from the right ventricle into the aorta and its various branches. At birth or very shortly thereafter, this fetal vascular channel is slowly obliterated by a remarkable process of proliferation in the ductus wall. The exact mechanism of this closure is still unclear but it is usually complete before three months of age. If it persists as a patent structure after three months, it is definitely abnormal and may constitute a serious functional abnormality.

There are two major hemodynamic abnormalities associated with the patent ductus. The first of these is related to the left ventricle and to the aortic circulation where the patent ductus constitutes a functional arteriovenous fistula. There is a continuous flow of arterial blood from the aorta into the pulmonary artery. It is this continuous flow, of course, which accounts for the machinery murmur which is pathognomonic of this condition. The proximal effect of this A-V fistula is primarily on the left ventricular myocardium which becomes hypertrophied with the increased work. The distal effect of the patent ductus shunt is decreased circulation to the lower extremities. This is seldom marked in childhood but occasionally there will be muscle cramps and cool feet associated with a large patent ductus. The collapsing nature of the peripheral pulse and the low diastolic pressure reflect the left-to-right shunting of blood from the aorta to the pulmonary artery.

The second hemodynamic abnormality is related to the effect of the left-to-right shunt on the pulmonary artery and its branches. The right ventricle continues to empty the normal cardiac output into the pulmonary system, but in addition, the quantity of blood which is shunted from the aorta through the patent ductus is added to this. There is then an increase in volume as well as an increase in pressure in the pulmonary artery system. This may have an immediate effect upon the infant. In those cases in which the flow is quite large there may be an acute problem of congestive failure. Occasionally it becomes necessary to operate upon such patients because of intractable congestive failure. Much more common, however, is the situation in which the increased flow of blood gradually produces changes in the pulmonary blood vessels. These alterations begin as intimal proliferation and proceed to medial hypertrophy and eventually atheromatous plaque formation in the pulmonary arteries. As this process continues there is the associated effect of narrowing of the pulmonary arteries resulting in increased peripheral resistance in the pulmonary vascular bed. When this occurs, the right ventricle must increase its pressurehead in order to propel the same quantity of blood through the lungs. The right ventricle becomes hypertrophied under this increased work load and there gradually developes right ventricular and pulmonary arterial hypertension. If this is allowed to proceed, these changes in the pulmonary vessels become permanent and eventually the pulmonary hypertension will equal the pressure in the aorta. At this point there is a balanced shunt in the patent ductus and as a final end result, there may develop reversal of flow so that the shunt is from right to left. These changes are obviously the terminal ones in an uncorrected patent ductus arteriosus and fortunately are very rarely seen today.

The diagnosis of a patent ductus arteriosus

is usually made on the basis of the typical continuous murmur and x-ray evidence of increased pulmonary vascularity. In atypical cases it may be necessary to resort to cardiac catheterization or retrograde aortography. The indication for operation is essentially the diagnosis itself. In the very young infant who is having no congestive problems it is probably wise to wait until the age of four or five years. In any event it is unwise to wait longer than is absolutely necessary because the pulmonary vascular changes are unpredictable ones and must be prevented by early obliteration of the patent ductus arteriosus.

The operative procedures have become standardized. The surgeon has two basic techniques available to him: division of the patent ductus or suture ligation of the intact ductus. Either method is quite satisfactory. The important principle is complete obliteration of flow in the ductus. The usual approach is through a left thoracotomy. The operative mortality and morbidity should be practically nil. Following interruption of the patent ductus arteriosus the prognosis is excellent for a normal life. On the other hand, if severe pulmonary hypertension has developed and extensive pulmonary vascular changes are present, there may remain some pulmonary hypertension following division of the patent ductus. In rare cases, when there is reversal of the shunt, it is impossible to divide the patent ductus because it is then acting like a pop-off valve or safety valve to the right side of the heart. These comments serve to reemphasize the importance of early diagnosis and prompt obliteration of the patent ductus arteriosus.

Coarctation of the Aorta

A third common extracardiac congenital abnormality is coarctation of the aorta. This congenital stenosis of the aorta may occur at different levels around the aortic arch and in the descending aorta but is most commonly found in juxtaposition to the ligamentum arteriosum. There are two major hemodynamic abnormalities associated with this condition. The proximal effect is due to the obstruction of flow and results in varying degrees of hypertension. The left ventricle hypertrophies under this increased work load. In infancy the left ventricle may occasionally fail because of inability to withstand this severe obstruction to arterial flow. In these rare instances of intractable congestive failure it is necessary to operate upon the infant and resect the coarctation in order to relieve this obstruction. In the usual case, however, the left ventricle adjusts to this increased work demand and the patient presents with hypertension in the upper extremities and either low blood pressure or no blood pressure in the lower extremities. This hypertension may have serious consequences over the years, resulting in extensive vascular changes in the upper extremity and cerebral circulation, aneurysm formation, and occasionally rupture of the aorta or of associated berry aneurysms in the circle of Willis. The second major hemodynamic effect occurs distal to the obstruction and is due to inadequate flow below the coarctation. This may result in ischemic changes in the musculature with claudication and retardation in muscular development in the lower extremities. The degree of inadequacy of peripheral circulation is directly dependent upon the development of collateral channels around the coarcted segment. If these collateral vessels are extensive the flow below may be quite adequate for normal development without symptoms of poor circulation. This development of collateral circulation requires a certain amount of time as is illustrated by the fact that the femoral pulses may be absent in early childhood but may become palpable as the child grows larger and reaches adulthood.

The diagnosis of coarctation of the aorta is usually first suspected when high blood pressure is determined in the upper extremities in the child with decreased femoral pulses. There is often an associated left ventricular hypertrophy demonstrable either on x-ray or by electrocardiogram. A soft systolic murmur can often be heard over the area of the coarctation. A definitive diagnosis can be made by retrograde aortography which will demonstrate the site of the coarctation. The indications for operation are somewhat different from those for patent ductus arteriosus. Because of the small size of the aorta in infancy and early childhood, it is preferable to wait until the child is ten to twelve years of age, at which time the aorta approximates the adult size and yet has usually not undergone any serious degenerative changes. If it becomes necessary to operate on

the child in infancy or early childhood for intractable congestive failure or subacute bacterial endocarditis, this can be done with a suturing technique employing interrupted sutures. This allows growth of the aortic wall between the sutures.

The operative procedure in the vast majority of patients is quite standard and is carried out through a left thoracotomy. The short coarcted segment is resected and an end-to-end anastomosis is carried out between the ends of the aorta. On rare occasions there will be a long segment of coarctation or hypoplasia of the aorta which will necessitate the use of some type of graft between the two ends but this is extremely rare in childhood and is uncommon in the adult. The results following resection of the coarctation are excellent. The blood pressure usually returns to normal and the prognosis for normal life is excellent.

Summary

In summary, three common extracardiac congenital heart abnormalities have been discussed and their functional significance in terms of altered cardiovascular dynamics have been emphasized. The diagnosis and surgical treatment of each of these abnormalities is usually uncomplicated, with an excellent prognosis in each instance.

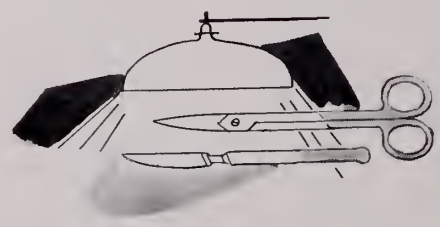
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Unilateral Thymic Cyst Of The Neck*

Cavit Ozlu, M.D., and John D. Allen, M.D.

Louisville, Ky.

The fifteenth case of a unilateral thymic cyst of the neck is presented, with a brief discussion of the anatomy, embryology, and the function of the thymus and thymic cysts of the neck in light of recent knowledge.

THIS is a case report of unilateral thymic cyst of the neck. A review of the literature revealed fourteen such cases reported under various titles. Hyde et al[1] reported the first case in 1944. In 1949, King[2] published eight cases of cystic tumors of the neck containing thymic tissue. He called these "Lymphoepithelial Cysts of the Neck." In 1951, another case was reported by Weller and associates.[3] In 1952, Laage-Hellman[4] removed a lateral cystic tumor in the neck of a thirteen-year-old girl. In 1957, two more cases were added by Williams et al[5] and Crawford and co-workers.[6] One was termed "Aberrant Cystic Thymus Gland of the Neck." Viar and associates[7] also reported a thymic cyst of the neck in 1959.

Case Report

A fourteen-year-old white girl complained of swelling in the left side of her neck for three weeks. Her general health had been good. There was no history of any previous medication, trauma, allergy, or infection of any kind that could be associated with this swelling.

The surgeon felt a non-tender, cystic mass in the left side of the neck anterior to the sternocleidomastoid muscle at about the level of the hyoid bone. There was no redness or induration over the movable cyst. It measured 4-5 cm. in diameter. Physical examination revealed a well-developed and well-nourished child in no apparent discomfort. Her temperature was 98.6° F., respirations 20/min., and blood pressure 118/60. All laboratory tests were within normal limits.

The cyst was removed intact without any difficulty. The postoperative course and convalescence were uneventful.

Gross Examination: The surgical specimen consisted of a cyst measuring 6 x 5 x 4 cm. Its external surface showed adherent, fibrous strands. The cyst contained dark brown, liquid, cloudy material. The inner surface was relatively smooth. The cyst wall measured from 0.1 to 0.9 cm. in thickness.

Microscopic Examination: The cyst wall was lined by a single or several layers of flat epithelial cells. The lymphoid tissue was divided by thin, fibrous septa. Typical Hassall's corpuscles were found in the medullary portion of the thymic tissue. The cortex was composed of lymphocyte-like small, round cells. (Fig. 1)

Discussion

Unilateral thymic cyst of the neck is a rare congenital malformation, usually diagnosed in childhood. Its clinical diagnosis is very difficult, but frozen section diagnosis is not a problem at all. The differential diagnosis consists of thyroglossal duct cyst, branchial cleft cyst and cystic hygroma.

Various names have been used for thymic cysts of the neck. We feel that the presence or absence of thymus gland in its usual place should determine the terminology. If the thymus gland is present, the cyst in the neck should be called an accessory thymic cyst of the neck. If

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Fig. 1. Showing cyst wall and thymic tissue with typical Hassall's corpuscles.

the thymus is absent, it would be correct to call it an aberrant thymic cyst of the neck. If the presence or absence of the thymus is unknown, then thymic cyst of the neck would be the correct terminology to apply.

In the previous fourteen cases, no mention was made of the thymus. In our case, we do not know whether the thymus gland was present or absent. However, it is difficult to demonstrate the thymus without surgical exploration.

At any age, surgical removal of an accessory thymus or accessory thymic cyst of the neck is justifiable because they have the potentiality of malignancy.[10] Surgical removal of an aberrant thymus or aberrant thymic cyst in the neck may not be justifiable before the age of puberty. The thymus may have something to do with normal development of the infant. In order to clarify this point, complete follow-up studies on a number of cases are necessary.

From the embryological standpoint, it is easy to explain the occurrence of a thymic cyst in the neck. According to Ham,[8] the thymic primordium derives from each side of the third pharyngeal pouches, each side contributing about equally. The abnormal cervical localization of thymus tissue is determined by an arrest of the thymic primordia as they descend through the neck structures toward the mediastinum. From a theoretical standpoint, it should be possible to find bilateral thymic cysts of the neck. We have not found any such reports in the literature. From the standpoint of embryology, one can readily make an assumption that thymic cysts are more likely to be accessory in nature. At least, one left or right thymic primordium descends down the anterior mediastinum and forms the thymus gland.

Our knowledge regarding the function of the thymus is growing.[8,9,11,12,13,14,15,16] At the time of birth, a normal thymus gland weighs about 10-15 grams. The growth hormone and the thyroid hormone stimulate the growth of the thymus. At puberty, it weighs about 30-40 grams. Most steroid hormones tend to bring about involution of the thymus. A substantial quantity of sex hormones in the circulation is probably an important factor in causing the thymus to involute at puberty.[8,11]

Selye[9] believes that premature involution of the thymus is caused by oversecretion of adrenal cortical steroid hormones as a result of disease or stress. There seems to be a reciprocal relationship between the amount of steroid hormone in the circulation and the size of the thymus gland.

From the above mentioned facts and observations, the status thymolymphaticus is interpreted by many authors as a result of underdeveloped adrenal cortices.[11]

It has been demonstrated that thymocytes differ from lymphocytes inasmuch as they have nothing to do with antibody production.[14,15]

There is a relationship between the thymus gland and lymphocytic leukemia in mice. In AKR mice, the thymus gland is often the site where lymphocytic leukemia begins. Radiation increases the incidence of leukemia in mice of strains that do not ordinarily develop leukemia to any great extent. However, if the thymus gland is removed from the animals before they are radiated, leukemia does not develop. Kaplan[16] has demonstrated that if a thymus gland from a non-radiated mouse is transplanted into a radiated mouse, leukemia will develop in the non-radiated thymus.

Because of the occurrence of myasthenia gravis in some patients with thymic cysts or cystic thymomas of the mediastinum, it is interesting to note that myasthenia gravis has

not been reported in any case of thymic cyst of the neck.

Summary

The fifteenth case of a unilateral thymic cyst of the neck is presented. A nomenclature is suggested for thymic cysts of the neck according to the presence or absence of the thymus gland in its proper place.

The anatomy, the embryology, and the function of the thymus and thymic cysts of the neck are discussed briefly in the light of recent knowledge.

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Circulatory Effects of Guanethidine in Hypertensive Heart Failure

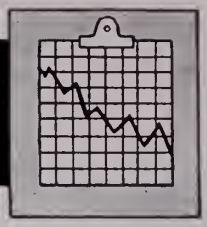
The hemodynamic and clinical data presented here suggest that guanethidine is a useful drug for the immediate and long-term management of hypertensive heart failure.

Effects of 10 to 20 mg. of intracardiac guanethidine on cardiac output and circulatory dynamics were studied in 7 patients with hypertensive heart failure, all of whom had a basal supine diastolic pressure of at least 110 mm. Hg and had not received any hypotensive or anticongestive therapy for the preceding 10 days. The immediate response in 5 of these patients was an increase of cardiac output, a decrease of ventricular filling pressure, and a reduction of systemic and pulmonary arterial pressures and resistance. The other 2 patients later came out of failure with oral guanethidine therapy, and it is possible that the dose or period of observation was inadequate. The pulmonary arterial pressures fell significantly in all 7 patients.

Guanethidine was administered orally for an average of 4 months to the above 7 patients and to 4 others with hypertensive heart failure. One patient died of myocardial infarction shortly after treatment was started, and the other 10 have become clinically well-compensated. Six patients came out of failure with guanethidine alone, 3 needed 1 or 2 mercurial injections, and 1 needed mercurials and digitalis.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Louisville General Hospital

Manic Depressive Psychosis

Carl L. Green, M.D.*

C. A.B. was admitted to the Louisville General Hospital in the fall of 1961. He was a 51-year-old well developed, moderately undernurished, unmarried white male. He was brought to the hospital by his brother who volunteered the following information. Three days prior to the patient's admission he was seen by neighbors in a nearby community standing in his front yard staring at the sky. He was later seen in his automobile heading toward home. The next day the neighbor, noticing the car in the yard, went over to see him and saw that all the windows of the car were broken. He found the patient in the kitchen of the house with a large can filled with kerosene, rocks, bread, broken glass, turpentine, skillets, molasses and many other things. He called this "Kick-a-poo-Joy Juice" and said he was going to drink it. He talked continuously of "religion, hurricanes, space men and beer," particularly "beer, beer, beer." He moved about continuously, laughing at times over serious topics and becoming angry without apparent provocation. He would not eat and when given a glass of water poured it on a cigarette and stated, "See, water puts out fire."

The family history revealed that the patient's maternal grandfather was in Central State Hospital sixty years ago for "nervous trouble" but was otherwise non-contributory.

In the patient's past history, we find that at six years of age he was supposed to have had pneumonia which the family's doctor said left "a scar on his lungs." In 1930 he was admitted to a sanitorium with a diagnosis of tuberculosis and remained there for five months. In 1939 the patient had an episode of illness similar to the present one and was admitted to Central State Hospital on May 11, 1939 and remained there until October 25, 1940.

As a child he was a normal, active boy. In school work he was frivolous and uninterested. His teachers told the family that he had ability but would not apply himself. He dropped out of school at the age of 16, being in the sixth grade at the time. His brother said that on occasions he stated the reason for not marrying was that he was afraid of giving tuberculosis to any children he might have. He was apparently a good worker in that he worked for the railroad for three years previous to the time he entered the sanitarium, following this and until his hospitalization in 1939 he worked on his father's farm and at odd jobs. From 1941 to 1958 he worked in brace shops and had a very good work record. In 1958 he went to their farm because of disagreements with his mother, with whom he had been living. His temperament was generally friendly and easy-going, although he was given to occasional periods of anger and depression.

Physical examination revealed no physical or neurological abnormalities. His Blood Pressure was 138/90, Pulse 86, Respiration 18, and Temperature 98.6. Laboratory work was normal. Hgb. 16.4; WBC 6,656; 70 Poly, 28 Lymph; 1 Mono; 1 Baso. Hematocrit (PCV) 50. Urinalysis: Gross Appearance—straw, clear; Specific Gravity 1.014; Alb. O; Sugar O; Micro. O. Blood VDRL—non-reactive. Spinal

*Chief Resident in Psychiatry, Louisville General Hospital.

Fluid VDRL—non-reactive. Spinal Fluid Chloride 123 mEq; Glucose 83 Mg %; Total Protein 27 Mg %. Pandy negative, no cells.

On admission to the hospital, he continued the same behavior pattern—exhibiting elation or irritation, over-talkativeness, flight of ideas, increased motor activity and transient, often momentary episodes of depression. He would rhyme words and pun. He was loud and refused to keep clothing on and at times was obscene. He seemed to be overly friendly when anyone was around and would shake hands as long as anyone would want to. When left alone, he would become very angry and would curse, refusing to eat and scattering food about the room.

He was unable to remember what had happened to him recently but had an excellent recall of things in the distant past. He was overly concerned with the fact that he had sinned and was going to be punished. He was oriented as to person, but not to time and place. He was above average in intelligence on tests given.

Diagnosis and Treatment

A diagnosis of Manic Depressive Reaction, Manic Type, was made and treatment instituted. This consisted principally of electroshock therapy, multiple vitamins and sedation as necessary, for the control of his hostility and aggressiveness. After two electroshock treatments the patient had calmed down, but was occasionally restless and combative, and was still rhyming and punning. After four treatments he was quiet and cooperative. He was given one more treatment, and, in view of the apparent control and the fact that his brother wanted to take him home with him, he was released on September 17, 1961.

On March 7, 1962, the patient was returned to the hospital because of a recurrence of abnormal behavior. He again exhibited increased psychomotor activity, a rapid flight of ideas, rhyming, punning, elation and anger, but did seem to be well-oriented as to time, place and person. Counting cards, he said, "1, 2, 3, Momma caught a flea, flea died, Momma cried." He was obviously misinterpreting things in that he would state that the voices on television and radio, while not directly accusing him of anything, were, to be listened to, nevertheless. He talked about seeing a woman "putting coal on a fire" and said she could be a member of his family.

He was again treated with electroshock therapy and, showing sufficient improvement, was again released to the care of his family on March 15, 1962.

On March 29, 1962, the patient was again returned to the hospital with similar behavior. It was stated that he had been well for several days but had resumed irrational, inappropriate behavior of such a legree that it was impossible to care for him at home. The patient was again given electroshock therapy but in view of the recurrence of the difficulty, it was decided to transfer him to the state hospital for long-term care. At present his prognosis is satisfactory with electroshock therapy and medication, principally tranqualizers.

This patient required eighteen months of treatment without electroshock therapy in 1939 to bring about a remission, whereas in 1961 with his modality, similar results were obtained in seven days.

This case re-emphasizes the fact that between episodes of psychosis, individuals with Manic Depressive Reaction can return to an apparently normal functional status. This patient was adjusted and productive for over twenty years in the first instance and then six months before the unpredictable reoccurrence.

Discussion

Charles W. Morris, Assistant Professor of Psychiatry: Our patient suffers from a "manic-depressive" illness. There is very little question about this, because of the clear symptom picture and because of the temporary responses to electroshock therapy. The unfortunate part is that we do not know enough yet about the interneuronal system-changes to be able to prescribe specifically for them. The best we can hope for is to change them, in a general way, enough with electroshock therapy that the basic disease process can in time run its self-limited course to spontaneous recovery. How similar this is to the cod-liver-oil-and-rest era in the treatment of tuberculosis?

It will be a day of rejoicing among all practitioners of medicine when psychiatric research can clearly spell out for us a specific chain of intracellular and intercellular neuronal changes which accompany the processes of emotional decompensation. Today, we are not at all sure which is the chicken and which is the egg. When we attempt to postulate a

neuronal mechanism which begins with "long continued emotional strain," we are often frustrated at the very beginning. Emotional decompensations, such as shown here in the aimless, frivolous, disorganized behavior of this patient, seems to occur in the course of just ordinary living. Specific "precipitating factors" are often hard to find.

We must conclude, either that we simply do not recognize these "precipitating factors," or that they do not in fact exist as such. If no real external inciting situations have occurred, then we should look for some internal changes in the emotional reactivity of our patient. And, of course, this implies some mediating interneuronal mechanisms, perhaps similar to disturbances of the sympathetic-parasympathetic balance of the autonomic system, but which must involve thalamoreticular-cortical pathways. The latter anatomical systems ordinarily interact with each other in a kind of balance which permits, or mediates, relatively efficient behavior. But, if the equilibrium between the systems is upset, behavior becomes relatively inefficient—"sick." We have classified the symptoms of such sickness, but we have yet before us the principal job of classifying the basic mechanisms involved. When we have don so, our treatment will be more precise and aimed at the fundamental disease process.

Harvey R. St. Clair, M.D., Assistant Professor of Psychiatry: This seems to be a typical case of manic depressive reaction. He showed the classical symptoms of euphoria and anger, flight of ideas, motor over-activity, rebellion against convention, rhyming and punning, and the usual loss of social controls in psychotically inappropriate ways. Fleeting depressive symptoms were also observed, as is the usual hase with the manic. He also showed the typical periodicity of the manic episodes.

So frequently, we are used to thinking that these people are normal in between their so called "attacks." This is not really the case. While these people are not psychotic from a clinical point of view in between their episodes of psychosis, they nonetheless are not truly normal people. We find that in their basic personality structure, they are always mood-oriented. These are people who are basically immature; they are more emotionally labile and seem to be people whose feelings and emotions and impulses are more in the driver's seat than judgement or a true consideration of the rights of others. It is needless to say that they are more narcissistic than the average adult. They get by with this pattern of personality functioning, and are often tolerated by others around them because their impulsive and mood-motivated behavior is not too far out of line.

There is another factor which makes these people not be labeled as "sick" by others, and that is their functioning as vicarious entertainment, and objects for identification, for other adults, who generally are more inhibited than these people. In fact, this level of functioning often becomes a role for them in relations to others. They come to find that their security and personal emotional needs are met by others liking them being somewhat uninhibited and this then becomes a role that they play. Without realizing it, they become, in various disguised ways, the entertainers and clowns in the subtle inter-plays between themselves and people. Once finding this they do not wish to give it up.

We find then, that when they become psychotic, it is only a marked exaggeration of what is already there anyway. What seems to make them decompensate into a psychotic episode is one of two things, or sometimes, both. Either painful conflict material from their unconscious threatens to invade consciousness, or intolerable external pressures can no longer be coped with.

From a psycho-dynamic standpoint, we are not sure whether these people in their psychosis, are running away from something that is intolerable to them, or whether they are throwing the inhibitions of their super ego overboard and rebelling in a wild, wish-fulfilling way. Perhaps something should be mentioned here, too, of the general consensus of opinion that there is at least some hereditary pre-disposition to have a temperament that is so emotionally dominated.

So far, depth psychotherapy has been quite disappointing in attempts to modify this basic personality structure except in a few of the milder cases. This leaves us, then, to treat the psychotic episodes with hospitalization, electroshock, chemotherapy, supportive psychotherapy and where possible, environmental manipulation.

George F. Doyle, M.D.,: Assistant Professor of Psychiatry: This case calls to mind the fact

that the frequency of manic depressive psychosis, manic type, is decreasing. Statistics from many sectors confirm this trend. We seldom diagnose a case of manic depressive psychosis, manic type, in private practice. In terms of treatment, these patients respond well to electric shock treatment and medication, particularly Thorazine. As this man shows, there are often long periods without recurrence, or the condition may recur with disturbing frequency. Those patients who tend to experience recurrences, whether of manic type, depressive type, or cyclic, may benefit from maintenance electric shock treatment and/or continuing medication, which may prevent the wide swings in mood responses. These patients are said generally to be poor candidates for psychotherapy, since they are either too sick or too well to benefit. My own experience has been that the person who can understand the character of his illness will indeed seek and benefit from psychotherapy, even in his free periods.

Manic depressive psychosis has been described in great detail, but so far we have very little real understanding of the condition. Perhaps the generally good prognosis for recovery has lessened the interest in this condition etiologically, in contrast to the interest in understanding schizopherania, which carries a much graver prognosis.

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1961

1962



Gaithel L. Simpson, M.D.
President



Henry B. Asman, M.D.
Vice President—Central



R. E. Pennington, M.D.
Vice President—Eastern



Walter R. Johnson, M.D.
Vice President—Western

President-Elect
David M. Cox, M.D., Louisville

Doctor Cox, a Louisville obstetrician, gynecologist, and surgeon, will be installed as president of the Kentucky State Medical Association on Wednesday evening, September 19, during the 1962 Annual Meeting.

Born in Nebo in Hopkins County, on May 31, 1898, Doctor Cox did undergraduate work at Transylvania College, Lexington. He then entered the Louisville Medical College where he received his M.D. degree in 1924. He was an intern in pathology and night anesthetist at Louisville City Hospital in 1924-25. Then he did intern and residency work in gynecology and surgery at Lakeside Hospital, Cleveland, Ohio, from 1925-27. He returned to Louisville City Hospital to become resident in surgery in 1927-28.

In 1928, Doctor Cox began a private practice in Louisville limited to gynecology and surgery. Two years later he opened his St. Matthews office (a suburb of Louisville) where he did general practice, including obstetrics, in addition to gynecology and surgery. In 1946 he limited his practice to gynecology, obstetrics and surgery.

During World War II, Doctor Cox served 44 months in various hospitals on surgical service. He was discharged as a Lieutenant Colonel.

Doctor Cox is an active member of the staffs of Kentucky Baptist Hospital and St. Anthony Hospital, Louisville, and has been on the gynecological teaching faculty of the University of Louisville School of Medicine since 1930. Other activities within his specialty field include membership in the Central Association of Obstetricians and Gynecologists and Fellowship in the American College of Surgeons.

An active member of organized medical groups, the new president was president of the Jefferson County Medical Society in 1954. He had previously served that group as treasurer and was active on several committees.

He has also been active with the KSMA. He was Vice President during 1959-60, has twice been a Delegate, and has served as chairman of the Professional Services Committee for several years.

In addition to his medical activities, Doctor Cox has done much work in church and civic affairs. His dedication, enthusiasm, ability, and integrity are only some of the qualities which led the House of Delegates to select him as president-elect.

VICE PRESIDENT, CENTRAL
Henry B. Asman, M.D., Louisville

A 1936 graduate of the University of Louisville School of Medicine, Doctor Asman limits his Louisville practice to colo-proctology. He began private practice in 1939 and was interrupted from 1942-46 when he served with the military in the European Theater. He is a Fellow of the American College of Surgeons and the Southeastern Surgical Congress and an Associate Fellow of the American Proctologic Society. He is a member of the Ohio Valley Proctology Society of which he is a past president. He has also been president of the Kentucky Division of the American Cancer Society and is now a member of the Board of Directors. Doctor Asman is on the staffs of several Louisville hospitals and has been clinical associate in surgery at the U. of L. medical school.

VICE PRESIDENT, EASTERN
R. E. Pennington, M.D., London

Doctor Pennington received his medical degree from the University of Pennsylvania, Philadelphia, Penn., in 1936. After internship at Philadelphia General Hospital, he was assistant in pathology at Western Reserve University, Cleveland, Ohio. He held a fellowship in surgery at the Mayo Foundation, Rochester, Minn., from 1939-41, and then became resident in surgery at the Mayo Clinic until he entered military service in 1942. In service until 1946, Doctor Pennington served two years in the China Theater and was awarded the Bronze Star for meritorious service in 1945. He opened a private practice, limited to surgery, in London, Ky., after discharge from the Army. He has been secretary of the Laurel County Medical Society and is also a member of the American College of Surgeons and the Southeastern Surgical Congress.

VICE PRESIDENT, WESTERN
Walter R. Johnson, M.D., Paducah

A native of Muskegon, Michigan, Doctor Johnson graduated from the University of Michigan Medical School in 1946. He took his internship and residency training in obstetrics and gynecology at the University of Michigan and entered private practice in Paducah in 1952. He is a diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Surgeons. A member of the Board of Directors of KEMPAC, he is a legislative key man from McCracken County and a delegate to the KSMA from McCracken County. Doctor Johnson is a member of the Board of Directors of the McCracken County Cancer Society and the county's Heart Association.

KSMA Secretary and Treasurer

SECRETARY
Woodford B. Troutman, M.D., Louisville



Elected to his first full five-year term as secretary in 1958, Doctor Troutman had previously served two years as interim secretary. He also was KSMA treasurer for 12 years from 1946 to 1958. A 1921 graduate of the University of Louisville School of Medicine, he interned at McKeesport Hospital in Pennsylvania and Bellevue Hospital in New York City. He interrupted his practice of general medicine in Louisville to study in Vienna, London and Edinburg. Upon his return, he began to limit his practice to cardiology. Doctor Troutman is active on all levels of the American Heart Association and is also a member of the American College of Physicians, and the Louisville Society of Internal Medicine.

TREASURER
Delmas M. Clardy, M.D., Hopkinsville



Doctor Clardy was elected KSMA treasurer by the House of Delegates in 1958 after he had served ar a delegate since 1936 and a District Councilor for six years. He received his medical degree from the University of Louisville School of Medicine in 1932 and limits his Hopkinsville practice to general surgery. He is a Fellow of the American College of Surgeons, a member of the Kentucky Surgical Society, and the Southeastern Surgical Congress. He is also a past president of the Christian County Medical Society. A native of Tennessee, Doctor Clardy served in the Medical Corps of the U.S. Army during World War II where he was chief of a surgical section of the 187th General Hospital in the European Theater.

KSMA Journal Editors

EDITOR
Sam A. Overstreet, M.D., Louisville

Doctor Overstreet first served The Journal of KSMA as scientific editorial editor. He was named editor of The Journal in 1958 following the retirement of the late Guy Aud, M.D. Under his direction, The Journal has made several changes in format and has added the new page on Questions and Answers About Your Blue Shield. A 1923 graduate of the University of Louisville School of Medicine, he has also served the KSMA as Centennial president in 1950-51. Doctor Overstreet has been president of the Jefferson County Medical Society and is governor of the Kentucky Chapter, American College of Physicians. He has served the KSMA in several capacities and is presently Speaker of the House of Delegates.

(A picture of Doctor Overstreet, who is also Speaker of the House, appears on page 756).

ASSOCIATE EDITOR
George W. Pedigo, Jr., M.D., Louisville



Named associate editor of The Journal in 1958, Doctor Pedigo has also served as vice speaker of the House of Delegates. He has also served the Jefferson County Medical Society at various dates as president, secretary and treasurer. He received his M.D. degree from the University of Louisville School of Medicine in 1938 and is now a member of the faculty of that school. He is a diplomate of the American Board of Internal Medicine and has been president of the Kentucky Society of Internal Medicine. Doctor Pedigo was elected to the Board of Directors of the Kentucky Chamber of Commerce.

AMA Delegates

Robert C. Long, M.D., Louisville



In 1958, Doctor Long was elected to his first full term after having been appointed delegate in December, 1957, to fill the unexpired term of the late Clark Bailey, M.D. Doctor Long has been active in affairs of the Jefferson County Medical Society and has also been president of the Louisville Obstetrical Society. A 1940 graduate of the University of Louisville School of Medicine, he took his internship and part of his residency training at Louisville General Hospital. He completed residency training at Chicago Lying-In-Hospital. Last year he presented KSMA's testimony on the King Bill before the House Ways and Means Committee.

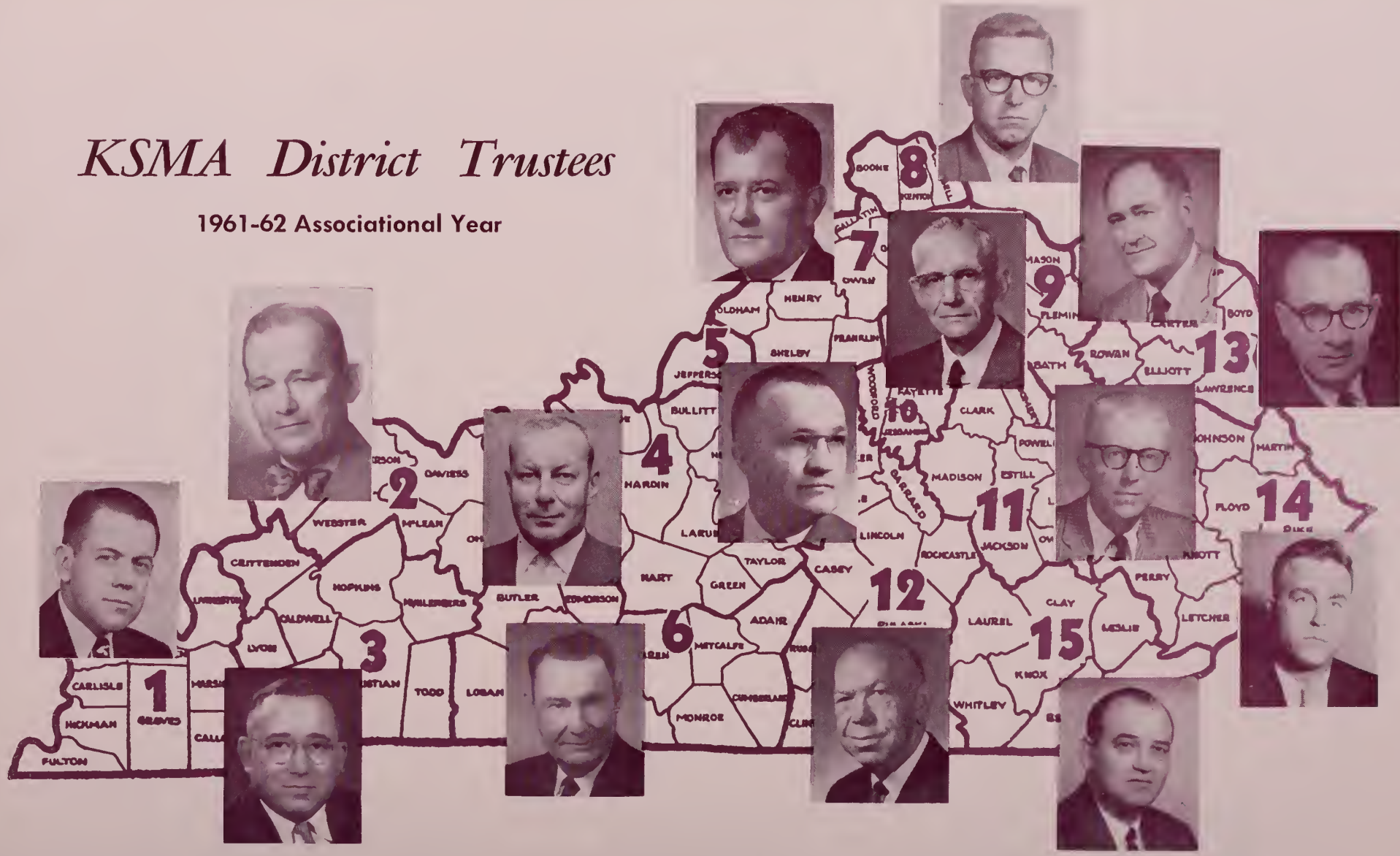
J. Vernon Pace, M.D., Paducah



Doctor Pace, a graduate of Vanderbilt University School of Medicine, Nashville, in 1921, has practiced in Paducah all of his professional career. He has long been active in his McCracken County Medical Society and social and civic affairs. He served two terms on the old KSMA Council and was chairman of that body one year. He is a charter member of the Board of Directors of the Kentucky Physicians Mutual—the Blue Shield Plan for Kentucky—and has served two years as its chairman. He was alternate delegate to the AMA before being elevated to the office of delegate to the AMA in 1961.

KSMA District Trustees

1961-62 Associational Year



1. HUGH L. HOUSTON — Murray
2. HOWELL J. DAVIS — Owensboro
3. RALPH D. LYNN* — Elkton
4. DIXIE E. SNIDER — Springfield
5. CARLISLE MORSE — Louisville
6. JOHN P. GLENN — Russellville
7. WYATT NORVELL*† — New Castle
8. DEXTER MEYER — Covington
9. MITCHELL B. DENHAM — Moysville
10. DOUGLAS E. SCOTT — Lexington
11. HUBERT C. JONES — Bereo
12. THOMAS O. MEREDITH* — Horrodsburg
13. CLYDE SPARKS — Ashlond
14. WILLIAM C. HAMBLEY* — Pikeville
15. KEITH P. SMITH* — Corbin

† *Chairman of Board*
* *Members of Exec. Committee*

AMA Delegates

George P. Archer, M. D., Prestonsburg

Elected to his first term as delegate to the AMA last year, Doctor Archer has served the KSMA as alternate delegate to the AMA and has been active in both community and medical affairs for many years. He received the KSMA distinguished service award in 1960. A graduate of the University of Louisville School of Medicine in 1941, he started practice in Paintsville in 1946 moving to Prestonsburg the following year. Charter member and first secretary of the KAGP, he served that group as vice president in 1958. He is a former chairman of the KSMA's council on Legislative Activities for National Affairs and a past president of the Floyd County Medical Society.



New Trustee

SECOND DISTRICT

Howell J. Davis, M.D., Owensboro

A former Vice President of the KSMA, Doctor Davis is a native of Whitley County. He received his medical degree from the University of Pennsylvania in 1933 after graduating cum laude from the University of Kentucky in 1929. He served a two-year internship at University Hospital and a surgical residency at St. Joseph Infirmary. Doctor Davis is a member of the American College of Surgeons, Kentucky Surgical Society, and the Southeastern Surgical Congress. He has practiced in Owensboro since 1936, with the exception of four and one-half years when he was in military service.

New Trustees

NINTH DISTRICT
Mitchell B. Denham, M.D., Maysville

Doctor Denham, a native of Lewis County, attended Eastern State College at Richmond, and graduated from the University of Louisville School of Medicine in 1940. He practiced for two years at Lynch before entering the U. S. Army Medical Corps where he served a three-year tour of duty ending in 1946. He has practiced in Maysville since that time. Active in civic affairs as well as those of his county medical society, Doctor Denham is a member of Rotary, the Farm Bureau, and the American Legion. He has represented his 65th District in the Kentucky Legislature since 1960, where he has emerged as an influential member.

THIRTEENTH DISTRICT
Clyde C. Sparks, M.D., Ashland

A past speaker of the KSMA House of Delegates and past president of the Association (1954-55), Doctor Sparks is a native of Lawrence County. He graduated from the University of Louisville Medical School in 1932 and until 1934 was on the surgical staff of Louisville General Hospital. He is a fellow of the American College of Surgeons and a member and past president of the Kentucky Surgical Society. Doctor Sparks has served as president of the staff of King's Daughters' Hospital and chief of its surgical service. He is a member of the Ashland Rotary Club. A veteran of naval service in World War II, he holds a commission as Commander in the Medical Corps of the Naval Reserve.

Election of Trustees

Trustees for five KSMA Districts will be elected by the House of Delegates at its second session on Wednesday, September 19. Nominations will be made at a caucus of the delegates from each district immediately after the first session of the House on September 17. The committee will report its nominees at the close of the first scientific session on Tuesday, September 18. Further nominations may be made from the floor at the second meeting of the House on Sept. 19. The five districts are: **First District** (incumbent Hugh L. Houston, M.D., Murray); **Third District** (incumbent, Ralph D. Lynn, M.D., Elkton); **Fourth District** (incumbent, Dixie E. Snider, M.D., Springfield); **Twelfth District,** (incumbent, Thomas O. Meredith, M.D., Harrodsburg); and **Fourteenth District** (incumbent, William C. Hambley, M.D., Pikeville). All except Doctor Lynn have served only one term and are eligible for re-election. Biographical information on new trustees elected in 1961 appears above.

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see map on preceding page

Officers of the KSMA House of Delegates

SPEAKER

Sam A. Overstreet, M.D., Louisville



Elected as Speaker at the 1959 session of the KSMA House, Doctor Overstreet is the fourth member to hold that office. President of the Jefferson County Medical Society in 1947, he has been active in medical affairs for many years and has served as Governor of the Kentucky Chapter, American College of Physicians. Besides his contributions of service to medicine, it is noteworthy that he has three sons who are physicians. Additional biographical information on Doctor Overstreet's activities appear under his write-up as Journal editor.

VICE SPEAKER

Garnett Sweeney, M.D., Liberty



After having served as chairman of the KSMA Council (now known as the Board of Trustees), Doctor Sweeney was elected vice president speaker at the 1959 Annual Meeting. He completed his second term as councilor from the twelfth district that year. President of the Kentucky Chapter, American Academy of General Practice in 1954, he has practiced medicine in Liberty sine 1940. A graduate of the University of Louisville School of Medicine in 1939 he interned at Charity Hospital, New Orleans, La. He is a former chairman of the KSMA Committee on Medical Education.

KSMA Delegates

ADAIR
George O. Nell, Columbia

ALLEN
Earl Oliver, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
J. W. Hunt, Jr., Wickliffe

BARREN
Eugene L. Marion, Glasgow

BATH

BELL

BOONE
Joseph F. Daugherty, Florence

BOURBON

BOYD
Guy C. Cunningham, Ashland

BOYLE
C. S. Jackson, Danville

BRACKEN
J. M. Stevenson, Brooksville

BREATHITT
Price Sewell, Jr., Jackon

BRECKINRIDGE

BULLITT
P. J. Murphy, Lebanon Jct.

BUTLER
John C. Burris, Morgantown

CALDWELL
William Jackson, Princeton

CALLOWAY
A. D. Butterworth, Murray

CAMPBELL-KENTON
Robert Hoffmann, S. Ft. Thomas
Donald Janney, Covington
James J. Kelly, Covington
Thomas McElhinney, Covington
Richard A. Allnut, Covington
Paul Klingenberg, Covington

CARLISLE

CARROLL

CARTER
J. Watts Stovall, Grayson

CASEY

CHRISTIAN
Guinn S. Cost, Hopkinsville
Gabe A. Payne, Hopkinsville

CLARK

CLAY
W. E. Becknell, Manchester

CLINTON
Ernest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
James Beck, Burkesville

DAVIESS
L. P. Moore, Owensboro
L. C. Dodson, Owensboro
William Woolfolk, Owensboro

EDMONSON

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
Omar C. Amstutz, Irvine

FAYETTE
C. H. Fortune, Lexington
Maurice Kaufmann, Lexington
R. D. Shepard, Lexington
Harvey Chenault, Lexington
N. L. Bosworth, Lexington
N. R. Gilliam, Lexington
L. E. Hurt, Lexington
E. D. Pellegrino, Lexington
J. H. Saunders, Lexington
E. C. Strode, Lexington

FLEMING
Robert W. Fidler, Flemingsburg

FLOYD
Russell L. Hall, Prestonsburg

FRANKLIN
James Ramsey, Frankfort

FULTON
R. Ward Bushart, Fulton

GALLATIN

GARRARD
O. S. Playforth, Lancaster

GRANT
Lenore P. Chipman, Williamstown

GRAVES
Robert Orr, Mayfield

GRAYSON

GREEN
R. L. Shuffett, Greensburg

GREENUP

HANCOCK

HARDIN
Charles F. Long, Elizabethtown

HARLAN
E. M. Howard, Harlan
David McL. Greeley, Harlan

HARRISON
H. H. Moody, Cynthiana

HART

HENDERSON
Kenneth M. Eblen, Henderson

HENRY
R. L. Houston, Eminence

HICKMAN
V. A. Jackson, Clinton

HOPKINS

JACKSON

JEFFERSON
Charles Bisig, Louisville
Austin Bloch, Louisville
Harold Eskind, Louisville
David Kinnaird, Louisville
Paul Mapother, Louisville
Harry Pfingst, Louisville
George Sehlinger, Louisville
David Thurman, Louisville
Robert Woodard, Jr., Louisville
C. Melvin Bernhard, Louisville
Ralph M. Denham, Louisville
James B. Douglas, Louisville
Robert L. McClendon, Louisville
William E. Oldham, Louisville
B. Frank Radmacher, Jr., Louisville
Henry G. Saam, M.D., Louisville
George I. Uhde, M.D.
Rudolph Vogt, Louisville
William VonderHarr, Louisville
Charles Bryant, Louisville
James Davis, Louisville
A. L. Goodman, Louisville
John Hemmer, Louisville
Richard Mardis, Louisville
Herman Moore, Louisville
James Riley, Louisville
John Robbins, Louisville
Bernard Shoo, Louisville
Sam Weakley, Louisville

JESSAMINE
J. S. Williams, Nicholasville

JOHNSON
James W. Archer, Paintsville

KNOTT

KNOX
F. X. Sommer, Barbourville

LARUE
J. D. Handley, Hodgenville

LAUREL
E. C. Seeley, London

LAWRENCE
William J. McNabb, Louisa

LEE
E. J. Broaddus, Beattyville

LESLIE

LETCHER
T. M. Perry, Jenkins

LEWIS

LINCOLN
H. I. Frisbie, Stanford

LIVINGSTON

LOGAN
W. R. Bryne, Russellville

LYON
M. H. Moseley, Eddyville

McCRACKEN
George H. Widener, Paducah

McCREARY

McLEAN

MADISON
Max E. Blue, Richmond

MAGOFFIN

MARION
Salem M. George, Lebanon

MARSHALL
William J. Colburn, Calvert City

MARTIN

MASON

MEADE
George E. Clark, Brandenburg

MENIFEE
Donald L. Graves, Frenchburg

MERCER
John S. Baughman, Harrodsburg

METCALF
P. D. Hitchcock, Edmonton

MONROE
W. F. Hurt, Gamaliel

MONTGOMERY
R. J. Salisbury, Mt. Sterling

MORGAN
R. L. Gullett, West Liberty

MUHLENBERG
C. J. Shipp, Greenville

NELSON
A. D. Steely, Bardstown

NICHOLAS
W. R. Kingsolver, Carlisle

OHIO
Oscar Allen, Beaver Dam

OLDHAM

OWEN
O. A Cull, Owenton

OWSLEY
Caleb H. Y. Chu, Oneida

PENDLETON
William M. Townsend, Falmouth

PERRY
Cordell H. Williams, Hazard

PIKE
Ballard Cassidy, Pikeville

POWELL
S. T. Scrivner, Stanton

PULASKI
B. L. Ramsey, Somerset
C. R. Faulkner, Somerset

ROBERTSON

ROCKCASTLE
J. D. Lewis, Mt. Vernon

ROWAN

RUSSELL
James E. Monin, Jamestown

SCOTT
R. G. Wheeler, Georgetown

SHELBY
Don Chatham, Shelbyville

SIMPSON

SPENCER
M. H. Skaggs, Taylorsville

TAYLOR
H. F. Chambers, Campbellsville

TODD
J. C. Woodall, Trenton

TRIGG
Thornton Bryan, Jr., Cadiz

TRIMBLE
Carl Cooper, Bedford

UNION

WARREN
Luther Martin Wilson, Bowling Green

WASHINGTON
R. A. Hamilton, Springfield

WAYNE
John W. Simmons, Monticello

WHITLEY
Harold Barton, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD
Olsen Parrott, Versailles

KSMA Nominating Committee Open Meeting Set

Following the close of the first session of the House of Delegates on Monday, September 17, the KSMA Nominating Committee will hold an open meeting. Members wishing to confer with the committee on nominees for general officers of the Association will have an opportunity to be heard at this time.

The committee will report its final recommendations at the end of the first scientific session on Tuesday morning, September 18. At the House of Delegates meeting on Wednesday evening, September 19 other nominations may be made from the floor without discussion or comment. The House of Delegates will vote on these nominees at the close of its second session on Wedneday, September 19.

The KSMA 1962 nominating committee includes: Russell L. Hall, M.D., Prestonsburg, chairman; W. H. Bryant, M.D., Glasgow; A. D. Butterworth, M.D., Murray; M. C. Darnell, M.D., Lexington; and William E. Oldham, M.D., Louisville.

Reference Committee Activity

All officers' and committee reports and resolutions will be referred to one of seven reference committees **at the first meeting of the House of Delegates** on Monday, September 17, by Speaker Sam A. Overstreet, M.D., Louisville. Reference committees will meet at **2 p.m. Tuesday, September 18 in air-conditioned second floor rooms** of the First Christian Church Annex, conveniently located near the Columbia Auditorium. Members of the committees should meet for briefing sessions at 1:45 p.m. **Any KSMA member wishing to testify on any resolution or report is urged to be present at 2 p.m.** In order to permit all who wish to speak to be heard, the open hearings will last at least an hour. The committees will go into executive session to study the reports and review the testimony given at the hearings, following the open hearings. The committees' recommendations will be made for presentation at the final session of the House in the Brown Hotel Roof Garden on Wednesday night, September 19. Reference committees appointed to serve during the 1962 session by Doctor Overstreet follow:

1962 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Reports of Officers and Board of Trustees

A. D. Steely, M.D., Bardstown, Chairman
T. M. Perry, M.D., Jenkins
Guy C. Cunningham, M.D., Ashland
George F. Widener, M.D., Paducah
W. R. Byrne, M.D., Russellville

REFERENCE COMMITTEE NO. 2

Scientific Assembly and Medical Education

J. S. Williams, M.D., Chairman, Nicholasville
Thomas McElhinney, M.D., Covington
Guinn S. Cost, M.D., Hopkinsville
George I. Uhde, M.D., Louisville
Robert Orr, M.D., Mayfield

REFERENCE COMMITTEE NO. 3

Legislative Activities

Melvin Bernhard, M.D., Louisville, Chairman
Robert W. Fidler, M.D., Flemingsburg
Robert L. Shuffett, M.D., Greensburg
John S. Baughman, M.D., Harrodsburg
Thornton Bryan, Jr., M.D., Cadiz

REFERENCE COMMITTEE NO. 4

Public Service and Allied Professions

Harvey Chenault, M.D., Lexington, Chairman
Charles F. Long, M.D., Elizabethtown
Richard A. Allnutt, M.D., Covington
Earl P. Oliver, M.D., Scottsville
James W. Archer, M.D., Paintsville

REFERENCE COMMITTEE NO. 5

Medical Service

B. F. Radmacher, M.D., Louisville, Chairman
David M. Greely, M.D., Harlan
R. Ward Bushart, M.D., Fulton
E. C. Strode, M.D., Lexington
Salem M. George, M.D., Lebanon

REFERENCE COMMITTEE NO. 6

Constitution & Bylaws; Special Committees

C. J. Shipp, M.D., Greenville, Chairman
Austin Bloch, M.D., Louisville
William Woolfolk, M.D., Owensboro
R. L. Houston, M.D., Eminence
M. Randolph Gilliam, M.D., Lexington

REFERENCE COMMITTEE NO. 7

Miscellaneous

James Ramsey, M.D., Frankfort, Chairman
J. W. Hunt, Jr., M.D., Wickliffe
Donald Chatham, M.D., Shelbyville
J. H. Saunders, M.D., Lexington
James Riley, M.D., Louisville

CREDENTIALS COMMITTEE

Harold Barton, M.D., Corbin
William Vonderhaar, M.D., Louisville
James J. Kelly, M.D., Covington

Annual Session High Lights



Columbia Auditorium, 824 S. 4th St., is site of Scientific Sessions and Scientific, Technical Exhibits

• **SCIENTIFIC SESSIONS,** featuring panel discussions and scientific presentations, are scheduled daily on Tuesday, Wednesday, and Thursday, September 18, 19, and 20.

• **THE HOUSE OF DELEGATES,** policy-making body of the KSMA, will hold two sessions during the Annual Meeting —one on Monday, September 17 and the final session on Wednesday, September 19. Officers for 1962-63 will be elected at the Wednesday night session. Both sessions in the Roof Garden of the Brown Hotel will be called to order at 7 p.m., following registration at 5:30 p.m. and a subscription dinner at 6 p.m.

• **FOURTEEN SPECIALTY GROUPS** will meet, with eight groups meeting on Tuesday afternoon, September 18, and six groups convening on Thursday afternoon, September 20. All KSMA members are welcome to attend any of these sessions.

• **THE PRESIDENT'S LUNCHEON,** featuring an address by F. J. L. Blasingame, M.D., executive vice president of the American Medical Association, will be held in the Crystal Ballroom of the Brown Hotel on Wednesday, September 19. Doctor Blasingame's topic will be: "Health Care and Politics." The three top KSMA awards will also be presented at the luncheon.

• **A TRANSATLANTIC CLINICOPATHOLOGICAL CONFERENCE** on Renal Disease will be conducted via the telephone between four distinguished British physicians and a panel of Lexington physicians. The CPC is set for 2 p.m. on Wednesday, September 19.

• **ALUMNI REUNIONS,** traditionally an adjunct of the Annual Meeting, are planned this year by five year classes of the University of Louisville School of Medicine, beginning with the class of 1912—which will be celebrating its 50th year. Members of the 1912 class will receive their 50-year buttons and will be recognized at the President's Luncheon.

Official Call

KSMA Annual Meeting

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KSMA will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday and Thursday, September 18, 19, and 20, 1962. The general session will be called to order at 9 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 7 p.m., Monday, September 17; the second regular session will begin at 7 p.m., Wednesday, September 19. Both sessions will be held in the Roof Garden of the Brown Hotel.

Registration

The registration desk will be open in the Roof Garden of the Brown Hotel from 5:30 p.m. to 8 p.m. on Monday, September 17, and Wednesday, September 19. It will be open in the Columbia Auditorium from 8 a.m. to 5 p.m. on Tuesday, September 18; Wednesday, September 19; and Thursday, September 20.

Annual Meeting Woman's Auxiliary to the KSMA

Tuesday, September 18

Pre-convention Board Breakfast: 8:45 a.m., Parlors A, B, C, Brown Hotel (subscription). Formal opening of 40th annual meeting, 10:30 a.m. South Room, Brown Hotel. Subscription Luncheon: 12:30 p.m. South Room, honoring past presidents, members-at-large, and distinguished guests. Tea Orientalé: 3:30 to 5 p.m. Louis XVI Room, Brown Hotel. All members and guests are cordially invited. Please sign at registration desk.

Wednesday, September 19

Continental Workshop Breakfast: 8:30-9:30 a.m., South Room, Brown Hotel; Subscription luncheon and style show: 12:30 p.m., Flag Room, Kentucky Hotel. Gavel Dinner: 7:30 p.m.

Thursday, September 20

Post-Convention Board Breakfast: 8:45 a.m., South Room, Brown Hotel (subscription).

All business sessions will be held in the Brown Hotel. Displays and exhibits in the South Room. Hospitality rooms 414-15-16.

Be sure to visit the Scientific and Technical Exhibits while attending the 1962 Annual Meeting of the KSMA.

Dr. Blasingame Featured Speaker at '62 President's Luncheon

"Health Care and Politics," a timely topic, will be the subject of the featured address at the 1962 President's Luncheon given by F. J. L. Blasingame, M.D., executive vice president of the American Medical Association.



The luncheon will be held at the Crystal Ballroom of the Brown Hotel on Wednesday, September 19, with Gaithel L. Simpson, M.D., KSMA president, presiding. Another feature of the luncheon will be presentation of awards by William H. Bizot, M.D., Louisville, chairman of the Awards Committee.

Doctor Blasingame, known to his friends as Bing, is a native of Arkansas. He received his medical degree from the University of Texas in 1932.

Long active in medical and civic affairs, he served as president of the Texas Medical Association in 1955 and was a member of the AMA Board of Trustees from 1949 until 1958. He was elected to his present position as executive vice president of the AMA in 1958, and was reappointed for another 5 year term in that office at the June meeting of the AMA House in Chicago.

KSMA's Three Top Awards Given at 1962 President's Luncheon

The three 1962 Award winners will be announced at the President's Luncheon on Wednesday, September 19, in the Crystal Ballroom of the Brown Hotel, according to William H. Bizot, M.D., Louisville, chairman of the Awards Committee.

The R. Haynes Barr Award recipient a layman who is active in the field of public health, is chosen by the Awards Committee. The committee also nominates physicians for the Distinguished Service Medal and the Outstanding General Practitioner Award. Selection of recipients for these awards is made by the House of Delegates on Monday evening, September 17, on the basis of the committee's nominations as well as nominations from the floor.

Serving with Doctor Bizot on the Awards Committee are: Neal Calhoun, M.D., Madisonville; Ollie Emerine, M.D., Elizabethtown; Samuel Flowers, M.D., Middlesboro; and E. W. Christensen, M.D., Lexington.

Last year A. Clayton McCarty, M.D., Louisville, received the Distinguished Service Award and Mrs. Eva Ray Wunderlich was awarded the R. Haynes Barr Award. The Outstanding General Practitioner Award was not presented in 1961.

1962 Annual Meeting Honors Pres. Lyman B. Todd

The 1962 Annual Meeting of the Association will be called The Lyman Beecher Todd Memorial Meeting in tribute to the 1881 President of the Kentucky State Medical Association.



The custom of honoring a past president or some distinguished Kentucky physician each year at the Annual Meeting was started in 1935.

A biography of Doctor Todd, written by KSMA historian Emmet F. Horine, M.D., Brooks, will appear in the program booklet which will be distributed at the meeting on September 18, 19, and 20.

KSMA president in 1880, Richard William Dunlap was honored at last year's meeting.

Med. School Alumni Reunions Set for Annual Meeting

Medical School alumni of the University of Louisville in 10 five-year classes will be holding reunions during the KSMA Annual Meeting, according to Les Shively, director of alumni relations at the University.

Classes holding reunions are: 1912, 1917, 1922 (plans not definite at press time), 1927, 1932, 1937, 1942, 1947, 1952, and 1957. Honored as it marks its golden anniversary will be the class of 1912. Its members will sit at a special table at the President's Luncheon and will be recognized. Special tables for any class requesting them will also be set up for other reunion classes.

For additional information about your class reunion contact your chairman. A list of chairmen follows:

1912 Hiram S. Eggers, M.D., Brown Building, Louisville
1917 Lytle Atherton, M.D., Brown Building, Louisville
1922 Plans indefinite at press time
1927 Robertson O. Joplin, M.D., Medical Arts Building, Louisville
1932 Sam Gordon, M.D., Heyburn Building, Louisville
1937 Charles Bryant, M.D., Medical Arts Building, Louisville
1942 Charles Rutledge, M.D., Hazard
1947 Stuart Urbach, M.D., Medical Arts Building, Louisville
1952 Robert S. Howell, M.D., Jewish Hospital, Louisville
1957 John W. Ambach, M.D., 4213 Cane Run Road, Louisville

KSMA Official Historian

Emmet Field Horine, M.D., Brooks

A 1907 graduate of the University of Louisville School of Medicine, Doctor Horine has been the official KSMA historian for many years. Each year he writes the biographical information on the past president of the Association which the meeting honors. Doctor Horine has cooperated with the building committee on the use of old medical literature and souvenirs to be used in the new headquarters office. A history of the Association which he wrote in 1951 in connection with the Centennial celebration was helpful as research material for the Dedication Program.



U. of L. Faculty to Entertain Alumni Tues., Sept. 18

The annual faculty cocktail party of the University of Louisville School of Medicine for alumni will be given Tuesday afternoon, September 18, during the Annual Meeting of the KSMA, J. Murray Kinsman, M.D., dean of the medical school announced.

The party will be held in the Crystal Ballroom of the Brown Hotel between the hours of 5 and 7 p.m.

Dean Kinsman said that while the function honors the alumni of the school all KSMA members attending the KSMA Annual Meeting are cordially urged to be present.

REGISTRATION

Please register at the Registration Booth in the west end of the Columbia Auditorium as soon as you are able. Hours are from 8 a.m. to 5 p.m. (EST), Tuesday, Wednesday, and Thursday, September 18, 19, and 20.

You are asked to wear your badges at all times while in the Auditorium.

KEEP UP TO DATE!
Be Sure to Visit the Scientific and Technical Exhibits at the KSMA ANNUAL MEETING September 18-20 at Louisville

'62-'63 Officers to be Elected by House on Sept. 19

KSMA Officers for the 1962-63 year will be elected at the second session of the KSMA House of Delegates on Wednesday night, September 19. Offices to be filled at that time are:

President-Elect (Eastern) one year
Vice Presidents (Central) one year
(Eastern) one year
(Western) one year

Delegate to the AMA: two years (incumbent, Robert C. Long, M.D., Louisville)

Alternate Delegate: two years (incumbent, J. Thomas Giannini, M.D., Louisville)

Speaker of the House: three years (incumbent, Sam A. Overstreet, M.D., Louisville)

Vice Speaker: three years (incumbent, Garnett J. Sweeney, M.D., Liberty)

The three-year terms of the following trustees expire in 1962. All except Ralph Lynn, M.D., Elkton, have served only one full term and are eligible for re-election.

First District (incumbent, Hugh L. Houston, M.D., Murray)

Third District (incumbent, Ralph D. Lynn, M.D., Elkton)

Fourth District (incumbent, Dixie E. Snider, M. D., Springfield)

Twelfth District (incumbent, Thomas O. Meredith, M.D., Harrodsburg)

Fourteenth District (incumbent, William C. Hambley, M.D., Pikeville)

KSMA by-laws specify that Trustees are limited to two consecutive terms and since Doctor Lynn is completing his second term he is not eligible for re-election.

1st Annual Diabetes Assoc. Meet in Louisville, Sept. 17

"How I Handle Diabetes" will be the topic of a talk to be given by L. O. Underdahl, M.D., Rochester, Minn., at the first annual meeting of the Kentucky Diabetes Association at the Brown Hotel at noon on September 17 — the day before the KSMA Annual Meeting.



Announcement of the meeting was made by Robert S. Tillett, M.D., president of the Kentucky Diabetes Association.

Doctor Underdahl, consultant in medicine, Mayo Clinic, and associate professor of clinical medicine, Mayo Foundation, Graduate School, University of Minnesota, graduated from the University of Minnesota Medical School in 1935. He was appointed to the staff of the Mayo Clinic in April, 1946.

The meeting will include a subscription luncheon and is open to both physicians and lay people. It is not necessary to be a member of the group in order to attend the meeting.

While at the Annual Meeting . . .

Four Special Phones

will keep you in touch with

Home or Office

You may be easily reached while attending the KSMA annual sessions, if you leave the **special phone numbers** listed below at your home and office, along with your schedule.

JUniper 3-1933 is the special KSMA number at Columbia Auditorium at the KSMA Headquarters Office, where all general scientific sessions will be held.

JUniper 4-6377 and **JUniper 4-6378** are the special numbers for physicians attending meetings at the First Christian Church. If you plan to attend any of five specialty group sessions or seven reference committee meetings at First Christian Church Tuesday afternoon, September 18—only—Call JU 4-6377 or JU 4-6378.

Or, if you plan to attend any of the five specialty group meetings at the First Christian Church Thursday afternoon, September 20, only—Call JU 4-6377 or JU 4-6378. **Do not call the First Christian Church number! Call either of our official numbers at the Church—JU 4-6377 or JU 4-6378.**

JUniper 4-1311 Roof Garden Kitchen extension is the special number to be called if you want to be reached either Monday evening, September 17, or Wednesday evening September 19, while attending the meeting of the KSMA House of Delegates in the Roof Garden of the Brown Hotel.

1962 Annual Meeting Program Summary

The Kentucky State Medical Association

September 17, 18, 19, and 20

Louisville

MONDAY, SEPTEMBER 17

12:30 noon	Board of Trustees Meeting	Louis XVI Room, Brown Hotel
5:30 p.m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p.m.	Subscription Dinner, House of Delegates	Roof Garden, Brown Hotel
7:00 p.m.	First Meeting of House of Delegates	Roof Garden, Brown Hotel

TUESDAY, SEPTEMBER 18

8:00 a.m.	Registration	Columbia Auditorium
8:45 a.m.	Opening Ceremonies	Columbia Auditorium
9:00 a.m.	First Scientific Session	Columbia Auditorium
11:00 a.m.	President's Address	Columbia Auditorium
2:00 p.m.	Specialty Group Sessions (Eight specialty groups will meet simultaneously. Any KSMA member may attend any of these meetings. See pages 764-766 in program.)	
	Reference Committee Meetings	First Christian Church, Annex

WEDNESDAY, SEPTEMBER 19

9:00 a.m.	Second Scientific Session	Columbia Auditorium
11:50 a.m.	President's Luncheon	Crystal Ballroom, Brown Hotel
2:00 p.m.	Third Scientific Session	Columbia Auditorium
	Transatlantic Clinicopathological Discussion—"Renal Diseases" featuring Physicians from Glasgow, Scotland, and University of Kentucky	Columbia Auditorium
5:00 p.m.	Board of Trustees Dinner	Louis XVI Room, Brown Hotel
5:30 p.m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p.m.	Subscription Dinner, House of Delegates	Roof Garden, Brown Hotel
7:00 p.m.	Second Meeting, House of Delegates	Roof Garden, Brown Hotel

THURSDAY, SEPTEMBER 20

9:00 a.m.	Fourth Scientific Session	Columbia Auditorium
12:00 noon	Board of Trustees Luncheon	Columbia Auditorium
2:00 p.m.	Specialty Group Meetings (Six specialty groups will hold their programs simultaneously. Any KSMA member may attend any of these meetings. See pages 767-768 in program.)	
5:00 p.m.	Adjournment	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

(Full Scientific Program starts on page 764)

SCIENTIFIC PROGRAM

Lyman Beecher Todd Memorial Meeting

The Kentucky State Medical Association

Columbia Auditorium, Louisville

TUESDAY, SEPTEMBER 18

Registration

8:45 **Opening of General Session**
Call to Order by President
Gaithel L. Simpson, M.D., Greenville, KSMA president
Invocation
Rev. Hugh Riley, Louisville, pastor, Douglass Boulevard Christian Church
Welcoming Remarks
Everett H. Baker, M.D., Louisville, president, Jefferson County Medical Society

FIRST SCIENTIFIC SESSION

Gaithel L. Simpson, M.D., president, presiding

Columbia Auditorium

9:00 **Panel Discussion—"Management of Heart Disease in Pregnancy"**
Walter S. Coe, M.D., Louisville, Moderator
Medical Aspects—Samuel H. Sandifer, M.D., Ft. Knox
Obstetrical Aspects—Curtis L. Mendelson, M.D., Abaco, Bahamas
Anesthesiological Aspects—Ray T. Parmley, M.D., Wichita, Kan.

10:30 **Visit Exhibits**

11:00 **President's Address**
Gaithel L. Simpson, M.D., Greenville

11:20 **"Some Important Health Problems in Underdeveloped Countries"**
James Halstead, M.D., Detroit, Michigan

11:40 **To be announced—**
Jose J. Centurion, M.D., Miami, Florida

Lunch—12:00 Noon

Specialty Group Meetings

Eight specialty groups will present scientific programs simultaneously and there will be no general session. Programs will be held either in the First Christian Church, the Columbia Auditorium, Calvary Episcopal Church, or First Unitarian Church.

Meetings will start at 2:00 p.m., and KSMA members are free to go from one group to another during the sessions.

Kentucky Society of Anesthesiologists

Room 44, First Christian Church

2:00 **"Injury to Teeth and Gums during Endotracheal Intubation"**
Max Ervin, M.D., Louisville

2:30 **"General Anesthesia for Surgery of the Middle Ear"**
Jack C. Wilhoit, M.D., Louisville

3:00 **"Influence of Anesthesia on Maternal and Infant Mortality and Morbidity—A 10-Year Study"**
Robert W. Lykins, M.D., Louisville

3:30 **"The Responsibilities of the Anesthesiologist to the Hospital"**
Ray T. Parmley, M.D., Wichita, Kansas

GUEST SPEAKERS

CURTIS LESTER MENDELSON, M.D.
Abaco, Bahamas



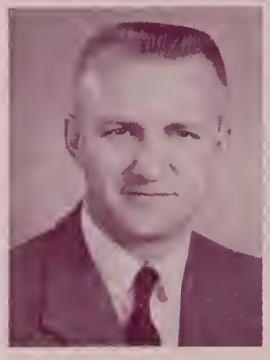
Fellow of American College of Surgreons; Fellow of American College of Obstetricions and Gynecologists; member of Internotionol College of Surgeons; former ossociote professor of clinicol obstetrics and gynecology, Cornell University Medicol College, N. Y., where he olso received his medicol degree in 1938; former ottending obstetrician and gynecologist, New York Hospitol; former director, Obstetric Cardioc Clinic, New York Lying-In Haspitol; former professor of obstetrics and gynecology, New York Polyclinic Medicol Schaal, former ottending obstetricion and gynecologist, New York Polyclinic Medicol School.

RAY T. PARMLEY, M.D.
Wichita, Kan.

Directar, Department of Anesthesiology, St. Francis Hospitol, Wichito, Kon.; Chairman of Committee on Anesthesiology, Kansos Medicol Society; vice president, Sauthern Society of Anesthesiologists; member of Residency Review Committee for Anesthesiology, Americon Medical Association; assaciote examiner, Americon Boord of Anesthesiology; M.D. degree from Tulane University, New Orleons, Lo., 1944; ossistont clinicol professar of surgery (anesthesiology), University of Konsas Medicol School, Kansas Medicol Schaal, Kansas City, Kan.; chief of onesthesiology, U. S. Novol Hospitol, Philadelphio, Po., during military service.



R. DREW MILLER, M.D.
Rochester, Minn.



Consultont in medicine in the Moyo Clinic ond ossociote professor of medicine in the Moyo Foundotion, Graduate School, University of Minnesota; ossaciote director of the Moyo Faundation; medicol degree from Northwestern University Medicol School, 1946; certified speciolist in internol medicine in 1953 by Americon Board of Internol Medicine; certified os specialist in pulmonory diseases in 1955; ossociote of the Americon College of physicions; fellow of the Americon College of Chest Physicians; member of the Committee on Physiologic Therapy of the Americon College of Chest Physicions.

Kentucky Chapter, American College of Chest Physicians

Choir Room, First Christian Church

A Symposium in Depth-Pulmonary Emphysema

2:00 "Physical Examination of the Emphysematous Patient"
William H. Anderson, M.D., Harlan
2:20 "Physiological Changes in Pulmonary Emphysema"
Douglas David, M.D., Louisville
2:40 "Radiological Changes in Pulmonary Emphysema"
Harold Rosenbaum, M.D., Lexington
3:00 Twenty-Minute Break
3:20 "Medical Treatment of Pulmonary Emphysema"
Jerome Cohn, M.D., Lexington
3:40 "Surgical Treatment of Pulmonary Emphysema"
William H. Potter, M.D., Harlan
4:00 "Prognostic Factors and Future Avenues of Research in Pulmonary Emphysema"
R. Drew Miller, M.D., Mayo Clinic, Rochester, Minnesota
4:30 Visit Exhibits

(Each presentation except Doctor Miller's will be fifteen minutes with a five-minute discussion period.)

Kentucky Obstetrical & Gynecologic Society

Columbia Auditorium

2:00 "Medical Care, Cardiovascular Surgery and Obstetric Management in the Pregnant Cardiac Patient"
Curtis L. Mendelson, M.D., Abaco, Bahamas
2:40 "Management of Incomplete Abortions at Wright-Patterson Air Force Base Hospital"
Capt. James R. Schrand, MC, Dayton, Ohio
3:00 Visit Exhibits
3:30 "Stimulation of Ovulation"
Philip S. Crossen, M.D., Lexington
4:00 "A Prescription for the Alleviation of Welfare Abuses and Illegitimacy"
H. Curtis Wood, Jr., M.D, Philadelphia, Pennsylvania
4:30 General Discussion and Questions

Kentucky Orthopaedic Society

Calvary Episcopal Church

2:00 "Anterior Cervical Fusion"
David Stevens, M.D., Lexington
2:30 "Treatment of Unstable Ankle Fractures"
Harold M. Childress, M.D., Jamestown, New York
3:00 "Some Aspects of Osteitis Pubis"
William Mitchell, M.D., Louisville
4:00 "Conditions about the Knee"
J. Leonard Goldner, M.D., Duke Hospital Durham, N. C.
4:30 Visit Exhibits

Kentucky Chapter American Academy of Pediatrics

Room 46, First Christian Church

2:00 "Jaundice in the Newborn Infant"
William A. Silverman, M.D., New York City
2:30 Discussion
3:00 "The Recognition of Heart Disease in Infants"
Jacqueline Noonan, M.D., Lexington
3:30 Discussion
4:00 Visit Exhibits

J. LEONARD GOLDNER, M.D.

Durham, N. C.



Prafessar af arthapaedic surgery, Duke University Medical Schaal, Durham, N. C.; graduate af University af Nebraska College af Medicine with M.D. degree in 1943; assistant resident in arthapaedics, 1946 and 1949, then resident arthapaedist, 1949-50, Duke University Haspital; arthapaedic resident 1947, and staff arthapaedic surgery, 1948 at Geargia Warm Springs Faundatian; resident in arthapaedics, Lincaln Haspital, 1949; certified by American Baard af Orthapaedic Surgery, 1952, member af American Academy af Orthapaedic Surgery, American Orthapaedic Assaciatian.

WILLIAM A. SILVERMAN, M.D.

New York, N. Y.

Assaciate prafessar af pediatrics, Calumbia University; graduate af University af Califarnia Medical Schaal, 1942; consultant pediatrician at fallawing haspitals: Greenwich Haspital, Greenwich, Cann.; Phelps Memarial Haspital, Narth Tarrytawn, N. Y.; Grasslands Haspital, Valhalla, N. Y. Gaad Samaritan Haspital, Suffern, N. Y.; assaciate attending pediatrician, Babies Haspital, and Vanderbilt Clinic; chairman af cammittee an Fetus and Newborn, American Academy af Pediatrics; member af subcammittee an Causes af Neanatal Death, Natianal Office af Vital Statistics; member of subcammittee an Cangenital Malfarmatians, Natiana! Office af Vital Statistics.



COL. SAMUEL H. SANDIFER

Fort Knox, Ky.



Chief, Department af Medicine, Ireland Army Haspital, Fart Knax, Ky.; calanel, Medical Carps, U.S. Army; consultant ta Praject Mercury; M.D. degree fram the Medical College af Sauth Caralina, Charlestan, S.C., in 1941; interned, Braake General Haspital, San Antania, Texas; resident, medicine, Medical College af Virginia; resident, cardialagy, Fitzsimans General Haspital, Denver Calarada. Certified in internal medicine, 1952; certified in cardialagy in 1960; Fellaw af American College af Physicians; member American Federatian far Clinical Research.

Kentucky Chapter
American College of Physicians

Breaux Hall, First Unitarian Church

2:00 **"Fact or Fancy—Electrocardiographic Left Ventricular Strain"**
Charles N. Kavanaugh, M.D., Lexington

2:30 **"The Place of Allergy in the Practice of Internal Medicine"**
John D. Lovett, M.D., Owensboro

3:00 **"Clinical Diagnosis of Congenital Heart Disease"**
Samuel H. Sandifer, Col., MC, Fort Knox

3:30 **"Hormonal Aspects of Peptic Ulcer"**
Raymond J. Timmerman, Fort Thomas

4:00 **Visit Exhibits**

Kentucky Chapter
American College of Surgeons

Fellowship Hall, First Christian Church

2:00 **"Current Status of Combined Surgery and Chemotherapy in the Treatment of Cancer"**
Ben Rush, M.D., Lexington

2:30 **"The Clinical Significance of Cancer Cells Circulating in the Blood of Patients"**
James C. Drye, M.D., Louisville

3:00 **"Reappraisal of Reconstructive Operation, Particularly Bypass Dacron Graft, in Patients with Obstruction of the Aorta and Iliac, Femoral and Popliteal Arteries"**
E. Stanley Crawford, M.D., Houston, Texas

4:00 **Visit Exhibits**

Kentucky Radiological Society

Room 43, First Christian Church

2:00 **"Renal Disease and Hypertension Radiologically Considered"**
William R. Eyler, M.D., Henry Ford Hospital, Detroit, Mich.

3:00 **Panel Discussion of Cases**
"The Cooperative Approach to Renal Disease"
(Doctor Eyler, an internist, a urologist and a radiologist)

4:00 **Visit Exhibits**

WEDNESDAY, SEPTEMBER 19
SECOND SCIENTIFIC SESSION

Columbia Auditorium

Henry B. Asman, M.D., Louisville, vice president (central), presiding

9:00 **Panel Discussion—"Management of Thoracic Emergencies"**
Jerome C. Cohn, M.D., Lexington, Moderator
Medical Apects—R. Drew Miller, M.D., Rochester, Minn.
Surgical Aspects—E. Stanley Crawford, M.D., Houston, Tex.
Radiological Aspects—William R. Eyler, M.D., Detroit, Mich.
Pediatric Aspects— William Silverman, M.D., New York City

10:30 **Visit Exhibits**

11:00 **"Development of the University of Kentucky School of Dentistry"**
Alvin L. Morris, D.D.S., Ph.D., Dean, U. of K. School of Dentistry, Lexington

11:20 **"Hyperbilirubinemia in the Neonatal Period"**
Gerard B. O'Dell, M.D., Richmond, Virginia

E. STANLEY CRAWFORD, M.D.
Houston, Texas



Associate professor of surgery, Baylor University College of Medicine, Houston, Texas; attending surgeon at Jefferson Davis Hospital, the Methodist Hospital, Veterans Administration Hospital, and St. Luke's Hospital, all of Houston, Texas; consultant in surgery, Texas Children's Hospital, Houston; graduate Harvard Medical School, 1946; certified by American Board of Surgery, 1954; certified by American Board of Thoracic Surgery, 1956, fellow of American College of Surgeons; member of Society of University Surgeons, American Association for Thoracic Surgery; Society of Vascular Surgery; International Cardiovascular Society.

WILLIAM ROSS EYLER, M.D.
Detroit, Mich.



Chairman, Department of Radiology, Henry Ford Hospital, Detroit, Mich., since 1955; assistant editor of "Radiology" Journal; assistant clinical professor of radiology, University of Illinois, 1952-1953; received medical degree from Harvard in 1943; captain, Medical Corps, U. S. Army, 1943-1946; resident in radiology, Massachusetts General Hospital, 1946-1949; staff radiologist, Massachusetts General Hospital, 1949-1952.

ALVIN L. MORRIS, D. D. S., PH. D.
Lexington, Ky.



Dean and professor of Oral Medicine, College of Dentistry, University of Kentucky; D.D.S. degree from University of Michigan School of Dentistry, 1951; Ph. D. degree in experimental pathology from University of Rochester School of Medicine and Dentistry, 1957; postdoctorate Research Fellow of the National Institute of Dental Research, U.S.P.H.S., University of Rochester School of Medicine and Dentistry, 1954-57; head of department of oral diagnosis, School of Dentistry of University of Pennsylvania, 1957-1961; vice chairman of Council on Dental Therapeutics, American Dental Association since Feb. 1962; member of advisory editorial board of Journal of Dental Research since 1960.

PRESIDENT'S LUNCHEON

Ballroom—Brown Hotel

11:45 a.m.

Gaithel L. Simpson, M.D., Greenville, presiding

Invocation

Rev. Wilfred T. Waterhouse, Rector, Calvary Episcopal Church, Louisville

Recognition

Gaithel L. Simpson, M.D.

Awards Presentation

William H. Bizot, M.D., Louisville, KSMA Awards Committee Chairman

"Health Care and Politics"

F J. L. Blasingame, M.D., executive vice president, AMA

THIRD SCIENTIFIC SESSION

Columbia Auditorium

R. E. Pennington, M.D., London, vice president, (eastern), presiding

2:00 **Transatlantic CPC**

3:00 **Visit Exhibits**

3:30 **Panel Discussion—"The General Aspects of Emotional Problems"**

S. Spafford Ackerly, M.D., Louisville, Moderator

The Internist's View—

R. K. Noback, M.D., Lexington

The Psychiatric View—

John C. Nemiah, M.D., Boston, Mass.

Musculoskeletal Aspects—

J. Leonard Goldner, M. D., Durham, N. C.

Headache and Vertigo—

Francis L. Lederer, M.D., Chicago, Ill.

THURSDAY, SEPTEMBER 20
FOURTH SCIENTIFIC SESSION

Columbia Auditorium

Walter R. Johnson, M.D., Paducah, vice president (western), presiding

9:00 **Panel on Athletic Injuries**

O. B. Murphy, M.D., Lexington, Moderator
R. J. Angelucci, M.D., Lexington
George Gumbert, Jr., M.D., Lexington

10:30 **Visit Exhibits**

11:00 **"Recent Developments in Diagnosis and Therapy of Enterpathogenic E. coli Diarrhea"**

Walter A. Murray, M.D., Columbus, Ohio

11:20 **"Enlarged Lymph Nodes: A Clinical Pathological Problem"**

Edward A. Gall, M.D., Cincinnati, Ohio

11:40 **"The Private Practitioner and his Relationship with Industrial Medicine"**

Mac Roy Gasque, M.D., New York City

Lunch—12:00 Noon

SPECIALTY GROUP MEETINGS

Six specialty groups will meet simultaneously on Thursday afternoon and there will be no general session. Programs will be held in the First Christian Church and the Columbia Auditorium.

All members are welcome to attend any of these sessions.

GERARD B. ODELL, M.D.
Richmond, Va.



Professor and Chairman, Department of Pediatrics, Medical College of Virginia; M.D. degree, Yale University School of Medicine, 1951; Commanwealth Fund Fellow, Cambridge University, Cambridge England, department of experimental medicine, 1953-54; Palia Foundation Research Fellow, Yale University department of pediatrics, 1954; instructor in pediatrics 1956-59, then assistant professor of pediatrics 1959-61, Johns Hopkins University School of Medicine; research assistant and assistant attending pediatrician, department of pediatrics, Sinai Hospital, Baltimore, Md., until 1961; chief of Newborn Service, Women's Clinic Johns Hopkins Hospital, 1957-61; Markle Foundation Scholar in Medical Science, 1959-61; Diplomate, National Board of Medical Examiners, 1952.

JOHN CASE NEMIAH, M.D.
Boston, Mass.



Psychiotrist, Massachusetts General Hospital; clinical associate in psychiatry, Bay State Medical Rehabilitation Clinic; associate in psychiatry and tutor in psychiatry, Harvard Medical School; editor of "Psychosamatic Medicine" from December 1961 to March 1962; presently book review editor of "Psychasamatic Medicine"; M.D. degree, cum laude, from Harvard Medical School, 1943; diplomate, National Board of Medical Examiners, 1944; certified in psychiatry, American Board of Psychiatry and Neurology, June 1951; member of American Psychasamatic Society, American Psychiatric Association, Boston Psychoanalytic Society.

FRANCIS L. LEDERER, M.D.
Chicago, Ill.



Professor of otolaryngology and head of the department, University of Illinois College of Medicine, Chicago, Ill.; chief of otolaryngologic service, research and educational hospitals of the University of Illinois, Illinois Eye and Ear Infirmary, Hines Veterans Administration Hospital; senior otolaryngologist, grant, Mt. Sinai, Michael Reese and Columbus Hospitals; consulting otolaryngologist, Presbyterian-St. Luke's Hospital; chief associate editor, Cyclopedia of Medicine, Surgery and Specialties; Fellow: American College of Surgeons, American Laryngological, Rhinological and Otological Society, Inc.; American Branchoesophagaologist Society, American College of Chest Physicians.

Kentucky EEN&T Society

Choir Room, First Christian Church

2:00 "The Challenge of Swellings"
Francis L. Lederer, M.D., Chicago, Illinois

2:30 "Staphylococcus aureus vs. Pseudomonas aeruginosa: A Study in Contrasts"
Henry F. Allen, M.D., Boston, Massachusetts

3:00 "Repository Vaccine in the Treatment of ENT Allergy"
Earl W. Christensen, M.D., Lexington

3:30 "Diagnosis of Heterotropia"
Charles T. Moran, M.D., Louisville

Kentucky Chapter American Academy of General Practice

Columbia Auditorium

2:00 "Hypoglycemia in the Neonatal Period"
Gerard B. O'Dell, M.D., Richmond, Virginia

2:30 "Pediatric Allergies"
Harry S. Andrews, M.D., Louisville

3:00 Visit Exhibits

3:30 "Orthopaedics in the Office or Emergency Room"
Charles F. Wood, M.D., Louisville

4:15 Discussion

Kentucky Industrial Medical Association

Room 46, First Christian Church

2:00 "The Industrial Physician's Relationship with Management"
Mac Roy Gasque, M.D., New York City

3:00 Panel Discussion—"The Physician's Role in Occupational Medicine"
Mac Roy Gasque, M.D., New York City
Charles E. Allen, Jr., M.D., Louisville
Gradie R. Rowntree, M.D., Louisville

Kentucky Society of Pathologists

Room 44, First Christian Church

2:00 "Adenomyosis: A Tissue Committee Analysis"
M. David Orrahood, M.D., Owensboro
"Structural Changes in the Rat Prostate Following Dithizone Administration"
Randolph Schrodt, M.D., Louisville

2:30 "A Study of Residual Lesions Following Diagnostic Conization of Cervix Uteri"
James E. Parker, M.D., Louisville
"Self-Healing Ventricular Septal Defects of the Heart"
William L. Miller, M.D., and Rudy Kovachevich, M.D., Louisville

3:00 "A Study of the Accuracy of Acridine Orange Fluorescence in Diagnostic Cytology"
Merritt Alcorn, M.D., Madison, Indiana
Recess

3:30 "Fatal Jaundice"
Edward A. Gall, M.D., Cincinnati, Ohio

Kentucky Psychiatric Association

Fellowship Hall, First Christian Church

2:00 "Group Psychotherapy as a Means of Approaching Homosexual Behavior Among Hospital Psychiatric Patients"
Kenneth B. Moore, M.D., Lexington
William T. Query, M.D., Lexington

2:30 "Experience with Lysergic Acid, L.S.D.-25, as a Therapeutic Adjunct"
Presley Martin, M.D., Louisville

3:00 "Dependency"
John C. Nemiah, M.D., Cambridge, Massachusetts

3:30 "Experiences in Developing the Louisville Mental Health Center"
Warren Cox, M.D., Louisville

Kentucky Association of Public Health Physicians

Room 43, First Christian Church

2:00 "The Structure of the U. S. Public Health Service and its Relationship to State and Local Health Departments"
Charles Fred Blankenship, M.D., Louisville

2:30 Discussion of Above Presentation

3:00 "Epidemiology and Control of Neomycin Resistant Enterpathogenic E. coli Diarrhea"

3:30 Discussion of Above Presentation

MAC ROY GASQUE, M.D.
New York, N.Y.



Carporote medical director, Olin Mathieson Chemicol Corparatian, New Yark, N.Y.; M.D. degree fram the University af Virginia in 1944; internship, University af Virginia Hospital; Diplamate, American Baard af Preventive Medicine in Occupatianal Medicine; associote clinical profassar af industrial medicine ot New Yark University Medical Center; lecturer in industrial medicine ot Duke University Medical Schoal; served in the U.S. Navy as a medicol afficer during Warld War II and again during the Kareon canflict: assaciated with Olin Mathieson for the past 14 yeors in variaus capacities.

EDWARD A. GALL, M.D.
Cincinnati, Ohio

Directar af pothology, Cincinnati General Haspitol and professar af pathalagy and chairman of the department of pathalagy ot the University af Cincinnati; groduate of Tulane University Medicol Schaol in 1931 with M.D. degree; directar af laborataries at Bethesda Haspital, Cincinnati, 1941-1948; editar-in-chief af the Americon Jaurnal af Pathology; member: Central Society far Clinical Research, Internatianal Academy af Pathology, American Assaciatian af Pathalagists and Bacterialagists, College af Americon Pathalagists, American Society far Experimental Pathalagy, and American Society for Clinical Pathalogists.



WALTER A. MURRAY, JR., M.D.
Columbus, Ohio



Research Fellaw, Natianal Science Faundation, September 1961-August 1963; clinical instructar af pediatrics, Ohia State University Schaal af Medicine, 1961; graduate af Carnell University Medical Callege with M.D. degree in 1955; internship, Cincinnati General Haspital, 1955-56; with U.S.P.H.S. Epidemic Intelligence Service, Cammunicable Diseose Center, Atlanta, Ga., July 1956—June 1958; assistant resident in pediatrics, Calumbus Children's Haspital, July 1958—June 1960, research fellaw, Raessler Faundatian, July 1960—June 1961; research fellaw, Natianal Science Faundotian, Sept. 1961—Aug. 1963.

Scientific Exhibits Expanded at 1962 Meeting

One hundred additional feet of space for the Scientific Exhibits in the foyer of the Columbia Auditorium is calculated to make the exhibits both more attractive and easily accessible, according to Alex Haller, M.D., Louisville, chairman of the KSMA Committee on Scientific Exhibits.

"Format of the exhibit has been changed and enlarged to give special emphasis to the Scientific Exhibits this year," he said.

For the first time, a medallion, as a first prize, will be awarded to the exhibit judged to be the best. In addition each exhibitor participating at this 1962 meeting will be awarded a certificate.

Scientific Exhibitors

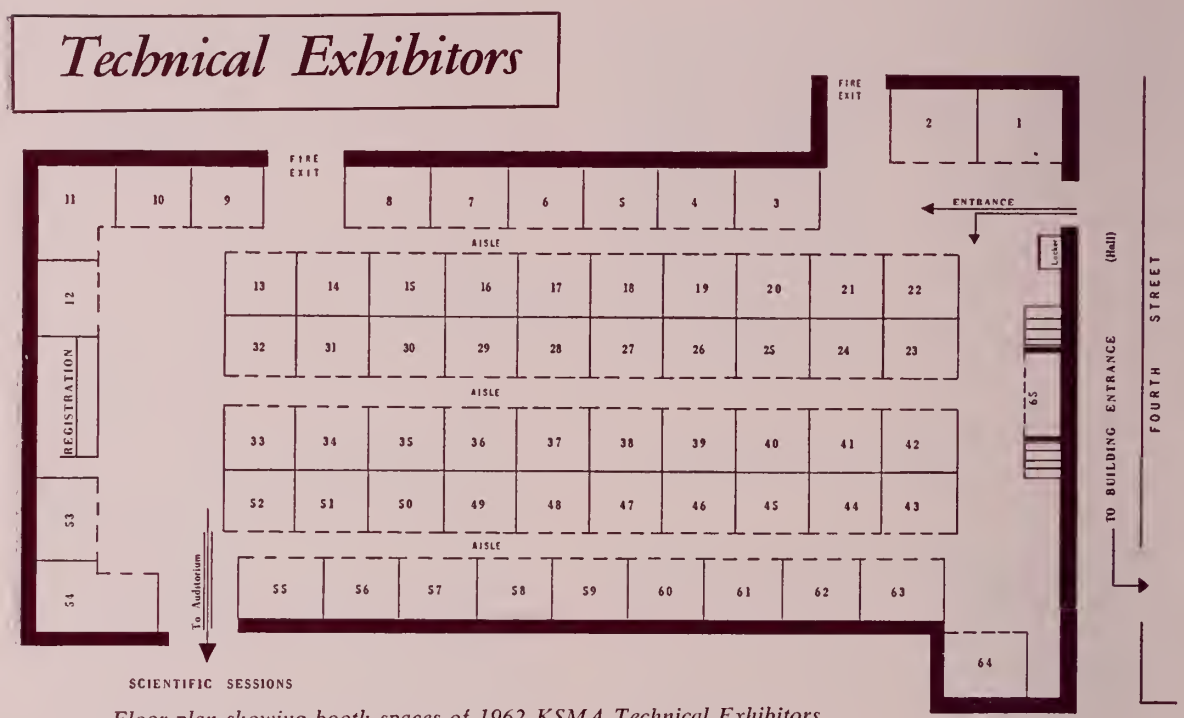
1. **Erythroblastosis Fetalis, Our Obstetrical Responsibilities**
   Herman A. Ziel, M.D., Jr., Hazard; Elwood Woolsey, M.D., Harlan; and Richard Stuntz, Harlan.
2. **Medical and Biological Illustrations**
   Blue Grass Chapter, Biological Photographic Society in cooperation with B. P. A. of University of Kentucky Medical Center and Veterans Hospital
3. **Full Thickness Skin Graft for Finger Tip Amputation**
   William T. Rumage, Jr., M.D., Univerity of Louisville, Department of Visual Education
4. **Abdominal Aneurysms: Prevention of Postoperative Renal Failure**
   David A. Hull, M.D., Lexington, and Gordon L. Hyde, M. D.,
5. **Diagnostic Laboratory Methods**
   Malcolm L. Barnes, M.D., Louisville
6. **Cancer of the Colon and Rectum**
   Coleman C. Johnston, M.D., James T. McClellan, M.D., and Duvon Corbitt, M. D., Lexington
7. **Primary Aldosteronism with Case Study**
   John B. Floyd, M.D., and Franklin B. Moosnick, M.D., Lexington
8. **Smoking—Medical Research and Practice**
   Kentucky State Department of Health—Division of Public Health Education
9. **Medical Aspects of Sports**
   KSMA School Health Committee
   R. E. Davis, M.D., chairman; Harry Denham, M.D.; Lee H. Vensil, M.D.; O. B. Murphy, M.D., James M. Keightley, M.D., Henry Wilbur, D.D.S.; Livingston A. Wahle, M.D., and Rusty Payne
10. **Library Facilities Available to Kentucky Physicians**
    Kornhauser Medical Library, University of Louisville Medical School and Jefferson County Medical Society
11. **One Light in the Laboratory**
    Kentucky Chapter, Arthritis and Rheumatism Foundation
12. **Study of Pulmonary Cavitus and Air Spaces**
    District Two State TB Hospital, Oren A. Beatty, M.D., and Alex Saliba, M.D.
13. **Symptomatic Peripheral Emboli**
    Benjamin B. Jackon, M.D.
14. **Percutaneous Transfemoral Renal Arteriography**
    University of Louisville School of Medicine, L. W. Howerton, Jr., M.D., T. R. Marshall, M.D., A. H. Joslin, M.D.
15. **Crash and Live**
    Kentucky Department of Public Safety in cooperation with the KSMA Highway Safety Committee
16. **Services to Physicians of Kentucky**
    University of Kentucky A. B. Chandler Medical Center

Technical Exhibits Planned To Be Varied, Outstanding

The technical exhibits scheduled for the 1962 Annual Meeting of the Kentucky State Medical Association promise to provide varied and outstanding items of interest to all in the profession, according to the outlined plans.

All members are urged to utilize the intermissions to visit all or as many as possible of these interesting presentations in order that they may study the progress being made in the many facets of the profession.

A 30-minute intermission is scheduled for each morning and afternoon Scientific Session during the Annual Meeting to provide time to visit both the Scientific and Technical Exhibits.



Floor plan showing booth spaces of 1962 KSMA Technical Exhibitors

Abbott Laboratories (23)
A. S. Aloe Company (63)
Ames Company (34)
Association of American Physicians & Surgeons (28)
Ayerst Laboratories (13)
Baker Laboratories (61)
Blue Cross-Blue Shield (24)
Burroughs Wellcome & Company (55)
Burton, Parsons & Company, Inc. (20)
Cameron Surgical Instrument Company (27)
Ciba Pharmaceutical Company (31)
Coca-Cola Company (64)
Desitin Chemical Company, Inc. (35)
Dictaphone Corporation (50)
Dietene Company (47)
Eaton Laboratories (62)
Geigy Pharmaceuticals (25)
Gerber Products Company (49)
Guild of Prescription Opticians of Ky. (39)
John Hancock (41)
Johnson & Johnson (9)
Kay Surgical, Inc. (11)
Lederle Laboratories—American Cyanamid Company (65)
Eli Lilly & Company (52)
J. B. Lippincott Company (15)
Lloyd Brothers, Inc. (37)
Logan Company (8)
McNeil Laboratories, Inc. 160)
J. A. Majors Company (43)
Malkin Instrument Company, Inc. (48)
Mead Johnson Laboratories (3)
Medco Products Company (6)
Medical Protective Company (19)
Merck Sharp & Dohme (42)
C. V. Mosby Company (57)
Ortho Pharmaceutical Corp. (14)
Pacific Medical Equipment Company (36)
Parke, Davis & Company (22)
Pfizer Laboratories (1)
Poythress & Company, Inc. (59)
R. J. Reynolds Tobacco Company (38)
A. H. Robins Company, Inc. (56)
Roche Laboratories (2)
J. B. Roerig & Company (30)
William H. Rorer, Inc. (7)
Ross Laboratories (18)
Sandoz Pharmaceuticals (10)
Schering Corp. (32)
Clayton L. Scroggins Associates (5)
G. D. Searle & Company (53)
Julius Schmid, Inc. (40)
Smith, Kline & French Laboratories (44)
Smith, Miller & Patch, Inc. (12)
E. R. Squibb & Sons (46)
Stuart Company (26)
United States Tobacco Company (17)
U. S. Vitamin & Pharmaceutical (54)
Upjohn Company (21)
Van Pelt & Brown, Inc. (4)
W-T-S Pharmaceuticals (29)
Warner-Chilcott Laboratories (45)
Warren-Teed Products Company (16)
Westwood Pharmaceuticals (58)
Winthrop Laboratories (33)
Max Wocher & Son Company (51)



Pictured is part of the course at Wildwood Country Club which will be the site of the KSMGA 1962 golf tournament. This is the first time the KSMGA tourney has been held on the "sporty" Wildwood course.

Wildwood Country Club Chosen as Site of 1962 KSMA Golf Tourney

Wildwood Country Club, located on Bardstown Road between Buechel and Fern Creek, will be the site of the 1962 Annual KSMGA golf tourney on September 18, 19, and 20. The Wildwood Club features the use of two lifts, similar to ski lifts, on hillsides.

Prizes will be awarded to those winning top honors in low gross, low net, and senior championship categories. Winners will receive the permanent prizes, plus one year's possession of traveling trophies.

Harold W. Baker, M.D., Louisville, chairman of the golf committee, in announcing this year's tourney stated that the permanent prizes to the three top winners would be purchased at Wildwood Country Club pro shop and will be exchangeable for anything of like value.

Winners last year included: D. M. Royalty, M.D., Lexington, the Championship Cup for low gross; Low Net Cup, John C. Quertermous, M.D., Murray; Senior Championship Cup, Thomas J. Overstreet, M.D., Lexington (a winner for the fourth consecutive year). Runner-up in the low net division was Earl Williams, M.D., Louisville.

Members serving under Doctor Baker on the Golf Committee are: Edwin P. Solomon, M.D., Louisville; James W. Archer, M.D., Paintsville; Clifton G. Follis, M.D., Glasgow; Martin Kaplan, M.D., Louisville; Kenton D. Leatherman, M.D., Louisville; Lanier Lukins, M.D., Louisville; and William C. Wolfe, M.D., Louisville.

If you wish to play in the KSMGA 1962 tourney please clip the attached application blank enclosing $6 (this includes both dues in the KSMGA and green fees).

CLIP HERE

APPLICATION FOR MEMBERSHIP
KSMA Golf Association

(Please complete and return immediately)

to: KSMA Golf Committee
Kentucky State Medical Association
3235 Janet Avenue
Louisville 5, Kentucky

Name .....

Street .....

Town .....

Cash enclosed is $6.00 ..... Check, $6.00 ..... Handicap .....

During the 1962 annual KSMA Golf Tournament, I would like to play September 18, 19, or 20 (Circle day or dates)

PROGRAM

FORTIETH ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

SEPTEMBER 18-19-20
1962

BROWN HOTEL
LOUISVILLE, KENTUCKY

REGISTRATION:

North Bay of Lobby, Brown Hotel
Monday 12 noon—5 p.m.
Tuesday 8 a.m.—5 p.m.
Wednesday 9 a.m.—11 a.m.

MONDAY, SEPTEMBER 17

3:30 P.M.

Finance Committee Meeting

TUESDAY, SEPTEMBER 18

Pre-Convention Board Breakfast: Parlors A, B, C Brown Hotel (subscription). All state officers, councilors, state committee chairmen, county auxiliary presidents, and the three immediate past presidents are urged to attend.

10:30 A.M.
SOUTH ROOM

Formal opening of the 40th Annual Convention of the Woman's Auxiliary to the Kentucky State Medical Association. Mrs. Guy Morford, President, presiding.

Invocation ..... Mrs. J. Andrew Bowen, Louisville, Kentucky, Blue Grass News Editor

Pledge of Allegiance to the Flag ..... Mrs. Keith Smith, Corbin, 1st Vice-President

Pledge of Loyalty ..... Mrs. Ballard W. Cassady, Pikeville, 4th Vice-President

Address of Welcome ..... Mrs. William C. Durham, Louisville

Presentation of Distinguished Guests .. Mrs. Guy Morford, Owensboro

Adoption of Convention Rules ..... Mrs. Earl W. Roles, Louisville, Parliamentarian

Announcements by Convention Chairman — Mrs. Robert C. Tate, Louisville

Roll Call of Delegates ..... Mrs. Robert J. Salisbury, Mt. Sterling, Recording Secretary

Minutes of the 39th Annual Convention — Mrs. Robert J. Salisbury

Report of the Board of Directors — Mrs. Robert J. Salisbury

Report of the 1962 National Convention — Mrs. George P. Archer, Prestonsburg

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association — Mrs. Charles B. Johnson, Russell

President's Address ..... Mrs. Guy Morford, Owensboro

Reports of Officers:

Report of Nominating Committee .... Mrs. Earl W. Roles

President-elect & membership chairman ..... Mrs. James S. Rich, Lexington

Treasurer ..... Mrs. William Hoy, Ashland

Corresponding Secretary ... Mrs. Charles C. Kissinger, Henderson, Prospect, Chairman

Presentation of the 1962-63 Budget . Mrs. Carlisle Morse, Louisville, Finance Chairman

Election of Nomination Committee for 1962-63

Old Business

New Business

Reports of Chairmen

Bylaws Revisions ..... Mrs. Earl W. Roles, Chairman

AMPAC-KEMPAC ..... Mrs. Earl W. Roles, Member of Board

Report of Registration ..... Mrs. John H. Prewitt, Lexington

In Memoriam ..... Mrs. Barton L. Ramsey, Somerset

12:30 P.M.
SOUTH ROOM
SUBSCRIPTION LUNCHEON

Honoring
Past Presidents, Members-at-large, and Distinguished Guests

Invocation ..... Mrs. Robert C. Tate, Louisville

Music

Address ..... Mrs. Roy A. Douglas, President, Woman's Auxiliary to the Southern Medical Assoc., Huntingdon, Tenn.

2:00 P.M.
SOUTH ROOM

Address ..... David M. Cox, M.D., President-elect, KSMA

Report of County Auxiliary Presidents "Advise and Consent" ..... Mrs. William Wainer, Director, Providence

Participants:

Daviess County, Mrs. J. W. Epperson, Owensboro
Fayette County, Mrs. Charles N. Kavanaugh, Lexington
Henderson County, Mrs. John Jenkins, Henderson

Hopkins County, Mrs. Duane Tweeddale, Madisonville
Green-Taylor County, Mrs. Henry Chambers, Campbellsville
Jefferson County, Mrs. William C. Durham, Louisville
McCracken County, Mrs. George Widener, Paducah

3:30 - 5:00 P.M.
Tea Orientale
Brown Hotel Louis XVI Room
Honoring Distinguished Guests

WEDNESDAY, SEPTEMBER 19

8:30 - 9:30 A.M.
SOUTH ROOM
CONTINENTAL WORKSHOP BREAKFAST
(fruit juice, coffee and doughnuts)

9:30 A.M.
SOUTH ROOM

Invocation ..... Mrs. J. Murray Kinsman, Louisville, Historian
Roll Call ..... Mrs. Robert J. Salisbury, Mt. Sterling, Recording Secretary
Reading of Minutes ..... Mrs. Robert J. Salisbury
Presentation of Distinguished Guests
Announcements ..... Mrs. Robert C. Tate, Louisville, Convention Chairman
Address ..... Gaithel L. Simpson, M.D., President KSMA
Address ..... Mrs. C. Rodney Stoltz, President-elect, Woman's Auxiliary to the AMA, Watertown, S.D.

Election of Officers
Installation of Officers ..... Mrs. C. Rodney Stoltz
Presentation of Gavel ..... Mrs. Guy Morford, Owensboro
Inaugural Address ..... Mrs. James S. Rich, Lexington
Announcement of Committee Chairmen Mrs. James S. Rich
Final Report of Registration ..... Mrs. John H. Prewitt, Lexington, Registration Chairman
Courtesy Resolutions ..... Mrs. Charles B. Stacy, Pineville

12:30 P.M.
LUNCHEON AND STYLE SHOW
(subscription)
Flag Room Kentucky Hotel
In Honor of
Mrs. C. Rodney Stoltz, President-elect, Woman's Auxiliary to the American Medical Association

Invocation ..... Mrs. Charles B. Johnson, Russell
Presentation of Distinguished Guests
Presentation of Past Presidents
Presentation of Officers
Presentation of Awards
Style Show
Commentator ..... Jean Hamilton
Adjournment

THURSDAY, SEPTEMBER 20

8:45 A.M.
SOUTH ROOM
Post-Convention Board Breakfast (subscription)
Presiding ..... Mrs. James S. Rich
Invocation ..... Mrs. Charles Kissinger
Meeting of Membership Committee

RULES OF THE CONVENTION

1. Badges must be worn by the voting body during all general sessions.
2. Delegates' privileges are transferable only with the knowledge and approval of the Credentials Committee.
3. Officers and delegates are requested to sit in the assigned seats.
4. When addressing the Chair, a speaker shall announce her name and that of her auxiliary.
5. Each speaker from the floor shall be limited to *two* minutes. No one shall speak more than twice on the same question.
6. Officers giving reports shall be limited to *five* minutes.
7. County presidents giving reports shall be limited to *two* minutes unless more time is specified by the president.
8. A time keeper shall notify each speaker when the allotted time has expired.
9. Only a voting member shall offer motions and vote. Motions must be in writing, signed by the mover, and presented to the recording secretary, when requested by the Chair.
10. No announcements shall be made from the floor. All announcements of a vital nature will be made from the platform after having been submitted in writing to the president, and with her approval.
11. The right to the floor may be granted to non-delegate members by consent of the Chair, or by majority vote of the delegates.

PLEDGE OF LOYALTY

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

1962 STATE CONVENTION COMMITTEES

General Chairman ..... Mrs. Robert C. Tate, Louisville
Co-Chairman ..... Mrs. Walter Coe, Louisville
Registration ..... Mrs. John Prewitt, Fayette County, Lexington
South Room Registration ..... Mrs. Ray Ulferts, Louisville
Luncheon Style Show:
General Chairman ..... Mrs. Robert Nolan, Louisville
Decorations ..... Mrs. S. Randolph Scheen, Louisville
Tickets ..... Mrs. David Cox, Louisville
Finance ..... Mrs. Austin Bloch, Louisville
Publicity ..... Mrs. Marvin Lucas, Louisville
Chairman of Tea ..... Mrs. Roy Martin, Louisville

Hospitality ..... Mrs. Douglas Haynes
Louisville

Official Hostesses ..... Mrs. Glenn W. Bryant
Louisville
Mrs. Carlisle Morse
Louisville
Mrs. Earl Roles
Louisville
Mrs. Charles B. Johnson
Russell

Exhibits ..... Mrs. Elbert Christian
Louisville

Tellers ..... Mrs. Hugh P. Adkins
Louisville
Mrs. Lewis Dickinson
Glasgow

Pages ..... Mrs. Robert Monroe
Louisville
Mrs. Elliott Podoll
Louisville
Mrs. Wendell Lynn
Ashland

Time Keeper ..... Mrs. W. Proctor Eubank
Louisville

STATE OFFICERS

President ..... Mrs. Guy Morford, Owensboro
President-elect ..... Mrs. James Rich, Lexington
First Vice President ..... Mrs. Keith Smith, Corbin
Second Vice President
Mrs. John Y. Barbee, Bowling Green
Third Vice President
Mrs. William S. Swartz, Lexington
Fourth Vice President
Mrs. Ballard W. Cassady, Pikeville
Recording Secretary
Mrs. Robert J. Salisbury, Mt. Sterling
Corresponding Secretary
Mrs. Charles C. Kissinger, Henderson
Treasurer ..... Mrs. William E. Hoy, Jr., Ashland
Parliamentarian ..... Mrs. Earl W. Roles, Prospect

ADVISORY COMMITTEE

F. Hays Threlkel, M.D., Owensboro
Earl W. Roles, M.D., Louisville
Robert N. McLeod, M.D., Somerset

IMMEDIATE PAST PRESIDENTS

Mrs. Jess T. Funk, Bowling Green
Mrs. Charles B. Johnson, Russell
Mrs. Earl W. Roles, Louisville

DISTRICT COUNCILORS

1st—Mrs. Hugh Houston, Murray
2nd—Mrs. William W. Wainer, Providence
3rd—Mrs. R. E. Davis, South Carrollton
4th—Mrs. J. M. Dishman, Greensburg
5th—Mrs. James E. Ryan, Louisville
6th—Mrs. J. Jack Martin, Tompkinsville
7th—Mrs. Harry J. Cowherd, Frankfort
8th—Mrs. Richard Rust, Fort Thomas
9th—Mrs. William H. Cartmell, Maysville
10th—Mrs. James S. Williams, Nicholasville
11th—Mrs. Arch B. Clark, Richmond
12th—Mrs. Barton L. Ramsey, Somerset
13th—Mrs. Paul F. Rizk, Grayson
14th—Mrs. George P. Archer, Prestonsburg
15th—Mrs. Garrett Craft, Harlan

Co-Ordinator For Members-At-Large—Mrs. J. Jack Martin, Tompkinsville

Committee Chairmen

American Medical Education Foundation
Mrs. C. Melvin Bernhard, Louisville
Benevolence .... Mrs. William M. Buttermore, Corbin
Bulletin ..... Mrs. Jess Funk, Bowling Green
By-Laws and Parliamentarian
Mrs. Earl W. Roles, Prospect
Blue Grass News, Editor
Mrs. J. Andrew Bowen, Louisville
co-Editor
Mrs. Marvin A. Lucas, Louisville
Cancer ..... Mrs. O. T. Evans, Louisville
Civil Defense ..... Mrs. William G. Clouse, Richmond
Community Service ..... Mrs. G. B. Froage, Paducah
Doctor's Shop .... Mrs. Carroll P. Price, Harrodsburg
Finance ..... Mrs. Carlisle Morse, Louisville
Health Careers
Mrs. George A. Buckmaster, Henderson
co-chairman ..... Mrs. N. B. Hasler, Louisville
Heart ..... Mrs. Paul Smith, London
Historian ..... Mrs. J. Murray Kinsman, Louisville
Legislation ..... Mrs. G. David McClure, Louisville
McDowell House .... Mrs. Walker Owens, Mt. Vernon
Mental Health ..... Mrs. Charles D. Clark, Murray
Nominations ..... Mrs. Earl W. Roles, Prospect
Past Presidents ..... Mrs. P. E. Blackerby, Louisville
co-chairman ..... Mrs. Victor P. Dalo, Louisville
Program ..... Mrs. Robert C. Long, Louisville
Rehabilitation .... Mrs. J. Murray Kinsman, Louisville
Rural Health ..... Mrs. A. B. Colley, Owensboro
Safety ..... Mrs. Dwight Blackburn, Berea
Tuberculosis ..... Mrs. Sam D. Taylor, Henderson

Past Presidents

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. P. E. Blackerly, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph L. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence
*1936—Mrs. Ernest Arthur Barnes, Albany
1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Mt. Vernon
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jess T. Funk, Bowling Green
1959—Mrs. Charles B. Johnson, Russell
1960—Mrs. Earl W. Roles, Louisville
*Deceased

SPECIAL ARTICLES

Kentucky-Cornell Automotive Injury Research*

BEGINNING August 1, physicians in selected areas in Kentucky will be asked to participate in the automobile-crash injury studies sponsored by Cornell University. Since its inception, the purpose of this research has been to collect reliable data on the specific causes of injury to occupants of cars involved in smash-ups, rather than on the causes of the accidents themselves.

Information from the states that cooperated several years ago served as a basis for the designing of passenger-protection devices such as the seat belts, improved door latches, energy-absorbing steering wheels, padding, etc., with which automobile manufacturers began equipping their cars in about 1955. Now, one of the purposes of the program is to collect data for use in evaluating the effectiveness of those recently adopted safety mechanisms, as well as in showing the need for additional protections.

Trauma produced in highway accidents is a "disease" endemic to the Western Hemisphere during the Twentieth Century, just as the bubonic plague, typhoid fever and malaria were seemingly ineradicable during the previous eras.

The Cornell studies employ the epidemiologic approach, and Kentucky is the twenty-fourth state in which the state medical society, the state department of health and the state police have agreed to cooperate. The other states are Indiana, North Carolina, Virginia, Maryland, Georgia, Connecticut, New York, Vermont, Pennsylvania, Minnesota, Texas, Colorado, Michigan, Arizona, California, Oregon, Ohio, New Mexico, Illinois, South Carolina, Wisconsin, North Dakota and Iowa. Cornell University Automotive Crash Injury Research Studies are sponsored by the USPHS and by the Automobile Manufacturers Association.

Several Protective Devices Have Helped

Thus far, the Cornell studies have shown that these safety devices are effective in preventing or in reducing the severity of injuries. In the injury studies that have been done on crashes involving the newer cars, it has been found that the incidence of door-openings during accidents has been reduced by one third.

As a result, the frequency of passenger ejection is down about 40 per cent, and the serious or fatal injuries have declined about 12 per cent. Yet, door latches haven't been made crash-proof, and if they could be so designed, the Cornell authorities are convinced, 5,500 additional lives could be saved each year.

When in use at the times of accidents, it is reliably estimated that seat belts account for a 35 per cent reduction in the risk of major or fatal injury.

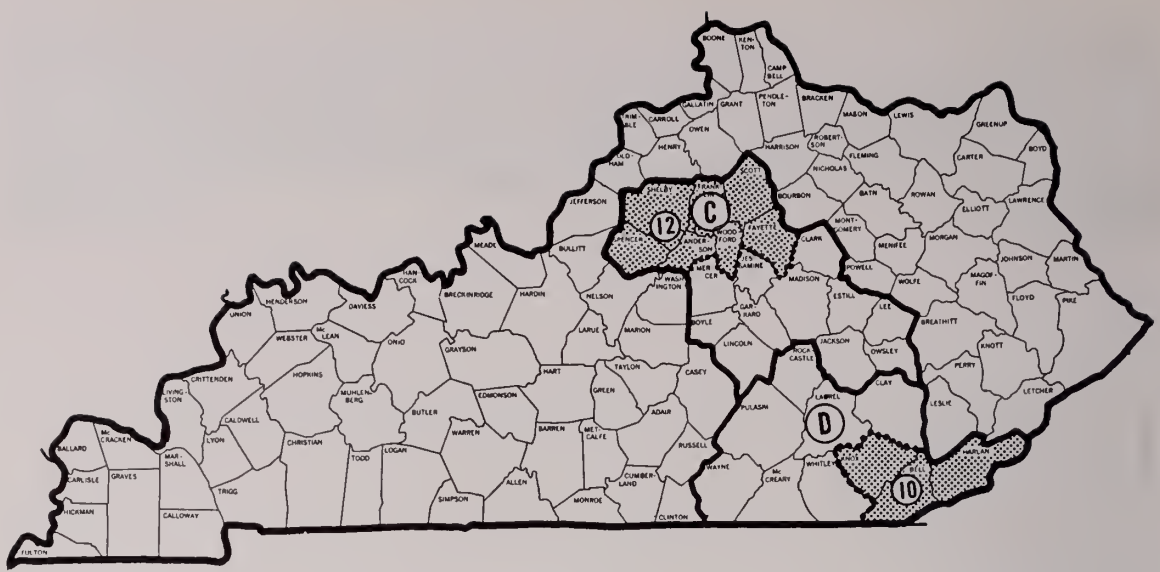
To date, Cornell University has collected insufficient data for a reliable evaluation of the efficiency of automobile padding and of shock-absorbent steering assemblies, but the evidence is at least beginning to show that the latter are lowering the incidence of severe chest injuries to drivers.

The Kentucky study is scheduled to last three years but doctors will be asked to provide medical information only during the six-month period in which their county is represented in the sampling area. On an average there will be fourteen counties included during any one period.

Counties included in the first sampling are: Anderson, Bell, Fayette, Franklin, Knox, Harlan, Scott, Shelby, Spencer, and Woodford.

Counties included in subsequent sampling periods: *Second*: Greenup, Boyd, Carter, Lawrence, Hart, Barren, Edmonson, Allen, Warren, Butler and Logan; *Third*: Gallatin, Carroll, Owen, Henry, Trimble, Oldham, Webster, Hopkins, Muhlenberg, Todd, Christian, Caldwell, and Crittenden; *Fourth*: Jefferson, Bullitt, Nelson, Larue, Hardin, Meade, Breckinridge, Grayson, Breathitt, Knott, Perry, Letcher, and Leslie; *Fifth*: Boone, Kent, Campbell, Grant, Bracken, Pendleton, Harrison, Robertson, Nicholas, Bourbon, Washington, Marion, Taylor, Casey, Green, Adair, Metcalfe, Russell, Cumberland, Monroe, Clinton; *Sixth*: Livingston, Lyon, Trigg, Calloway, Marshall, McCracken, Ballard, Graves, Carlisle, Hickman and Fulton.

*See editorial on page 778



Injuries sustained in accidents in shaded areas involving passenger cars and investigated by the Kentucky State Police are to be reported for the Cornell Automotive Crash Injury Research project's first sampling period which began Aug. 1, 1962 and ends January 31, 1963.

When one or more occupants in a passenger car have been injured, the state police officer assigned to investigate the accident will have two extra tasks to perform: (1) to answer certain questions and take photographs for the Cornell investigators: and (2) to deliver the required number of copies of the physician's report form to the hospital emergency room or doctor's office where the injured were taken (or to the county medical examiner for passengers killed in the crash).

The hospital employees will give the forms to the attending physician and when they have been filled in, they will be forwarded by the hospital to the State Department of Health.

The physician will find that the form which he is asked to complete is a brief one, and since it is anticipated that reports will be sought on no more than three injured individuals per day in the average fourteen county study area, the likelihood is small that any particular doctor will need to report on more than four or five occasions.

The Division of Accident Prevention of the State Department of Health will receive the reports from the State Police and from the doctors (in most instances through the hospitals where the patients have been cared for), and will forward them to Cornell University.

Conclusion

Physicians are urgently requested to participate in this effort, for it is aimed at solving one of the nation's foremost epidemiologic problems. Unless the injuries of each person hurt or killed in a passenger car accident within the sampling area are carefully recorded, the effectiveness of the study and the value of the data that it produces will be seriously reduced.



EDITORIALS

Syphilis Again

IT IS common knowledge now that the incidence of syphilis is increasing, after its notable twenty-five-year decline. The increase has been steady in the United States since 1954, and in Louisville and Kentucky since 1958. The number of early infectious cases in Kentucky rose from 43 in 1957, to 82 in 1960, and 142 in the nine months, July, 1961, through March, 1962. In the United States as a whole a figure of 6,250 in 1957 increased to an estimated 20,000 in 1961.

There has been a parallel rise in incidence of gonorrhea in the nation, and a slight increase in Kentucky. Some of this may be only apparent, and due to the recent application of fluorescent antibody in a diagnostic test, especially in females.

Even though the frequency of new cases of syphilis is vastly lower now than it was before the Public Health Service began work on the problem in 1935, the statistics cited suggest a real danger that syphilis might get out of control in spite of present public health activities. Greater efforts are needed. But where should such efforts be directed?

Education

In general, throughout the country, an increasing proportion of cases of early syphilis are being found among persons 15 to 24 years old. This points to failure to instruct the young about venereal disease. There seems to be less publicity now on the subject than twenty years ago. Rarely do school teachers discuss venereal disease in the classroom, and hygiene classes usually skip over matters of sex. At a recent meeting of health department and educational executives in Louisville, the City and County Boards of Education promised to take up this matter with their Parent-Teacher Associations and try to start such teaching as soon as possible. The Medical Society will be consulted about the material to be taught. Unfortunately the representative of parochial schools was of the opinion that venereal disease teaching should not be done in those schools.

An interesting and apparently effective means of public education has been tried in Los Angeles: A 24-hour telephone answering service played a 1-minute recorded venereal disease message. It was run continuously for 37 days, during which more than 180,000 calls were received, and an average of 70 persons daily inquired of medical associations for names of local physicians who treated venereal diseases.[1]

Case-Finding

The most effective means of discovering new cases of syphilis is contact investigation. In general, this is well conducted by specially trained investigators in the public clinic, but it is in general very poorly done by the private physician. The latter's responsibility should not stop when he has diagnosed and treated and "followed-up" his patient's early syphilis, but requires also that he at once obtain the names of close contacts and take measures to see that these are examined and treated, or given prophylaxis. If the private doctor prefers not to carry out this public health function himself, he can call upon the local health department, whose investigator will interview the patient, and, preserving the patient's anonymity, will investigate his contacts.

Contact tracing both here and elsewhere has revealed in recent years an increased number of cases of syphilis among male homosexuals. It has also long been observed that syphilis is much more frequent in certain social groups than in others. Hence comes the growing practice of cluster testing, i.e. testing not only the patient's sex contacts but also his associates, among whom may be found other cases, leading to other chains of infection.

A High Level of Suspicion

Since the earlier striking decline in incidence, most physicians see very few patients with early syphilis in private practice, and have therefore become less aware of the disease and more likely to overlook it. Chancres are often far from typical, and secondary lesions may simulate other dermatoses. Both darkfield examination and serologic testing are too often omitted. And, incidentally, very few laboratories have personnel qualified to identify the *Treponema pallidum*.

The time has not yet come when physicians can lower their level of suspicion of syphilis. Apparently the old fire is doing more than smoulder. It seems likely that any doctor at any time may encounter infectious syphilis in his practice. He should, therefore, if necessary, refresh his knowledge of the subject.[2]

Oscar Bloch, Jr., M.D.

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1. Beerman, Herman, M.D., et al: Syphilis, Review of the Recent Literature, Archives of Internal Medicine, 109:323, March, 1962.
2. Syphilis, Modern Diagnosis and Management, United States Department of Health, Education, and Welfare, 1960. (Obtainable through the Health Department)

Kentucky – Cornell A.C.I.R.

THE union of these names signals a new attack in this State on our mounting highway death and injury toll. The word "Cornell" has become synonymous with crash injury research yet the formal creation of the Automotive Crash Injury Research program at Cornell Medical College dates only from 1952.

Initial impetus came from Hugh de Haven who survived serious injuries in a mid-air collision when a Royal Canadian Air Force cadet of World War I. First studies of the Crash Injury project in 1942 were concerned with "free falls." Under World War II stimulus this led to broader studies of air crash injuries.

U. S. Army concern with loss of military personnel in auto accidents in the early 1950's brought one phase of the Cornell work heavily aimed at highway problems. By formal agreement with the Department of Safety, Department of Health, Kentucky Hospital Association and the KSMA, Kentucky will on August 1, 1962 become the 24th State to participate in these intensive data collection and analysis projects.

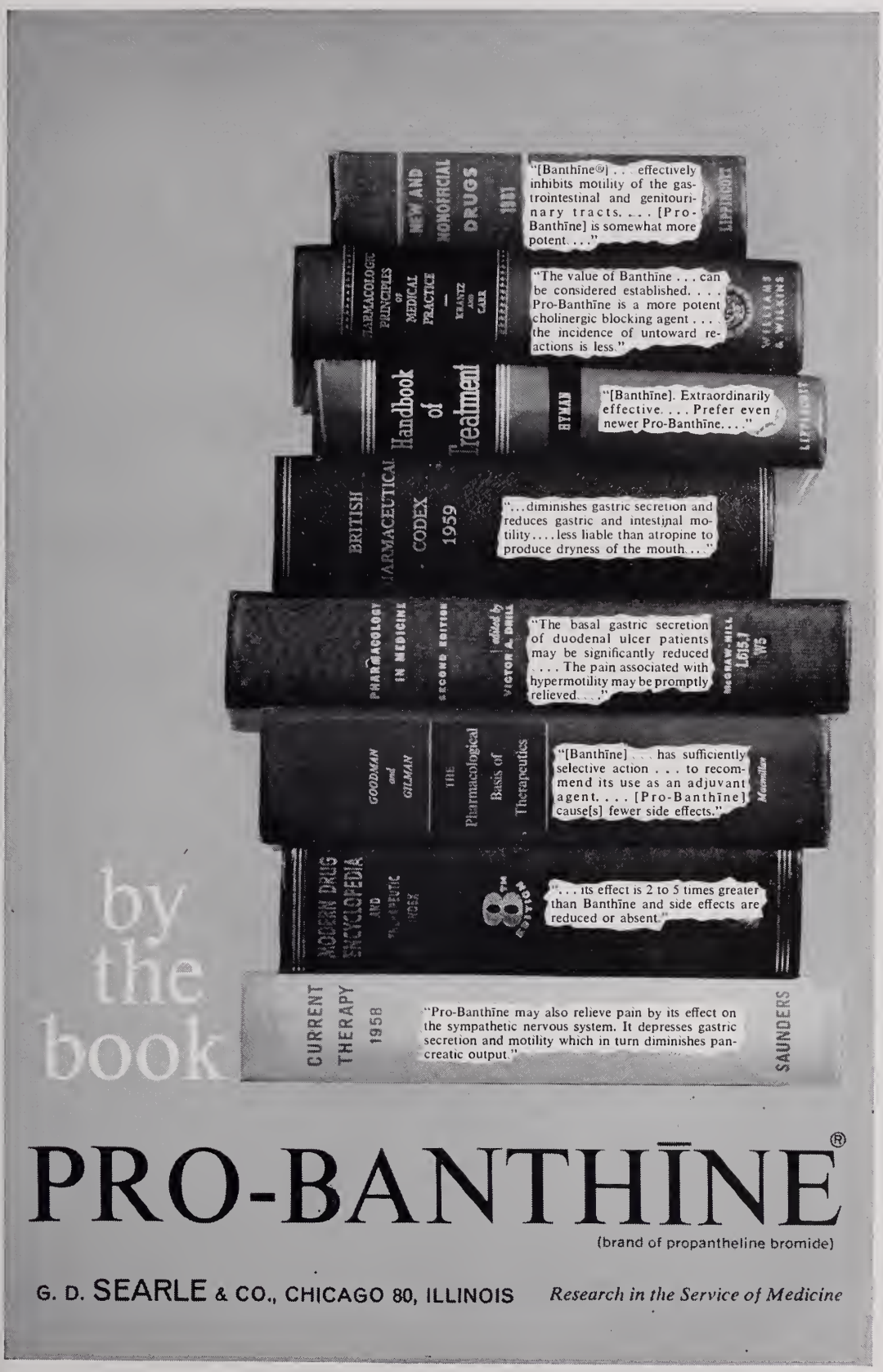
Primary responsibility for on-the-scene studies will be assumed by the Division of State Police under Col. David Espie. KSMA physicians will assist in the compilation of medical reports. The Division of Accident Prevention (State Dept. of Health) will collate police with medical reports and maintain weekly summaries. The Kentucky Hospital Association will assist in securing of hospital and emergency room reports in keeping with tested Cornell procedures. All data will be IBM processed at Cornell and made available as statistics for any qualified user. The ultimate goal is critically accurate data on which automobile design and Kentucky highway practices can be altered to reduce death and injury.

State troopers will initiate Cornell reports on approximately every eighth, fatal or injury producing accident involving passenger vehicles, other than single vehicle accidents. Truck, bus, pedestrian, motorcycle accidents, etc., are excluded. This sampling will produce about 70 detailed reports per month without excessive burden on physicians or troopers.

Sampling areas will cover three to eleven counties at a time and be operative for periods of six months each. The Kentucky-Cornell project will embrace six sampling periods over three years. Mr. Richard C. Braisted and a small field staff from Cornell will begin informational meetings with State Police posts, county medical societies, and hospital groups during the last two weeks in July and before activation of each successive sampling area.

The study in Kentucky is unfortunately timely as our accident and death rates have jumped ahead of those in contiguous states and well ahead of the national average. When called on occasionally for the additional emergency room burden of another medical report, Kentucky physicians can render valuable service that may save future lives and reduce emergency room catastrophes.

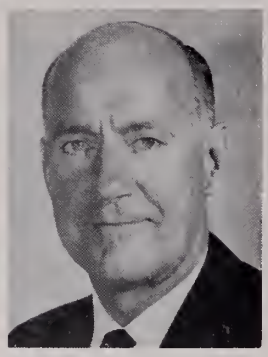
Arthur H. Keeney, M.D.
Chairman, Highway Safety Committee
Kentucky State Medical Association


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ORGANIZATION SECTION



Dr. Fister



Dr. Annis

Dr. Annis New AMA Pres.-Elect Dr. Fister Installed as Pres.

Medicine's chief spokesman against socialized medicine, Edward R. Annis, M.D., Miami, Florida, was chosen by the House of Delegates of the American Medical Association as its president-elect at its Chicago meeting in June.

Installed as the 116th president of the American Medical Association was George M. Fister, M.D., Ogden, Utah. The inauguration was in the International Ballroom of the Conrad Hilton Hotel. Gaithel L. Simpson, M.D., Greenville, KSMA president, was among 50 State presidents taking part in the ceremony. A picture of the Kentucky delegation at the inauguration appears on page 784.

A member of the Board of Trustees since 1957, Doctor Fister has also been a member of the AMA House of Delegates. He limits his practice to urology. Doctor Fister succeeds Leonard W. Larson, a pathologist from Bismarck, N. D.

Doctor Annis, familiar to television viewers for his debates and speeches on behalf of organized medicine, has appeared in Louisville on various occasions. He spoke here during the 1961 Annual Meeting and has also spoken before groups in Lexington and at a civic meeting in Owensboro. He is chairman of the AMA National Speakers Bureau.

Other officers elected include: J. P. Culpepper, Jr., Hattiesburg, Miss., vice president; Norman A. Welch, M.D., Boston, re-elected speaker of the House, and Milford O. Rouse, M.D., Dallas, Tex., re-elected vice speaker.

Allied Council's Health-O-Drama at '62 State Fair

With the theme—"Kentucky's Health is Her Future"—a Health-O-Drama, sponsored by the Council on Allied Medical Services will be on display in the east wing of Freedom Hall during the Kentucky State Fair, September 7-15.

This is the first year in which there will be a cooperative health exhibit at the Fair. In the past, individual members of the Allied Council, including the KSMA, have had separate exhibits. The Allied Council is made up of the KSMA, the Kentucky Dental Association, the Kentucky Pharmaceutical Association, the Kentucky Hospital Association, and the Kentucky Association of Registered Nurses.

Purpose of Exhibits

Purpose of the exhibits is to inform the people of Kentucky of the contributions made by the various health groups and of the health services available to help make them among the healthiest in the U. S.

At press time, there was a good possibility that the "Transparent Twins"—a new AMA exhibit—will be on display. Should the "twins"—(a male and female —operating on the same principle as the"Transparent Woman" which physicians saw at the Annual Meeting in 1961) not be available, the "Transparent Woman" will be exhibited.

A number of free health services will be provided, including a mass glaucoma screening and free chest x-rays. Fair officials expect more than 400,000 persons to visit the exhibit.

Idea for the Health-O-Drama came from the Canadian National Exhibition which had a similar health exhibit in 1960 and 1961.

Auto Accident Kills Dr. A. E. Cole

Arch Evan Cole, Ph. D., professor of anatomy at the University of Louisville School of Medicine, was killed in a head-on collision in Marion County, Ohio, on September 13. Doctor Cole, who came to the U. of L. in 1929, had formerly been assistant professor of anatomy at Northwestern University.

At the U. of L. Medical School he was director of admissions from 1951 to 1959, and acting chairman of anatomy since January. Medical school students five times voted him the "preclinical professor of the year," the latest in 1961.

Doctor Cole did under-graduate work at Ohio Wesleyan University and received his Ph. D. degree in anatomy from the University of Wisconsin in 1920. He was 67.

At the time of the accident, Doctor Cole was on his way to Plymouth, Ohio, on family business. He was a member of Sigma Xi, scientific honorary society and was active in church work.

Date Set For Annual Fall Clinical Conference

October 10 has been set as the date for the Seventh Annual Fall Clinical Conference sponsored by the Lexington Clinic and the Kentucky Academy of General Practice. The Conference will be held at the Lexington Clinic Building.

A morning symposium will be on the subject, "The Management of Acute Trauma." An afternoon symposium will be centered around the discussion of "Staphylococcal Infections." Members of the Lexington Clinic will present a total of ten brief papers in connection with the two symposia and there will also be several guest speakers. The complete program for the meeting, which has been submitted to the AAGP for approval for six hours of Category I Credit, will appear in the September issue of The Journal.

Some of the guest speakers will be: Harold E. Kleinert, M.D., associate professor of surgery, University of Louisville School of Medicine; W. A. Altemeier, M.D., professor of surgery, University of Cincinnati; and Frederick A. Horner, M.D., department of pediatrics, University of Kentucky School of Medicine.

Indiana State Med. Dedicates New Headquarters

David M. Cox, M.D., president-elect, and Henry B. Asman, M.D., vice president (central), represented the Association at the dedicatory services of the new Indiana State Medical Association building in Indianapolis on July 15.

Harry R. Stimson, M.D., Gary, president of the Indiana State Medical Association presided at the services, which included an address by George M. Fister, M.D., president of the American Medical Association.

The building is in the contemporary style and includes space for all the association's activities—both present and future.

U of L Appointments, Grants Announced by Board

A grant of $10,000 from the Avalon Foundation for Medical Scholarships was announced by the Board of Trustees of the University of Louisville in July.

Another grant for $500 was given by Mrs. A. W. Homberger to be added to the Homberger Memorial Library Fund in the School of Medicine's Department of biochemistry.

Also announced were the promotions of Walter T. Hughes, M.D., and R. D. Brooke Williams, M.D, to assistant professors of pediatrics.

Dr. Cecil Receives AMA Award for Distinguished Service

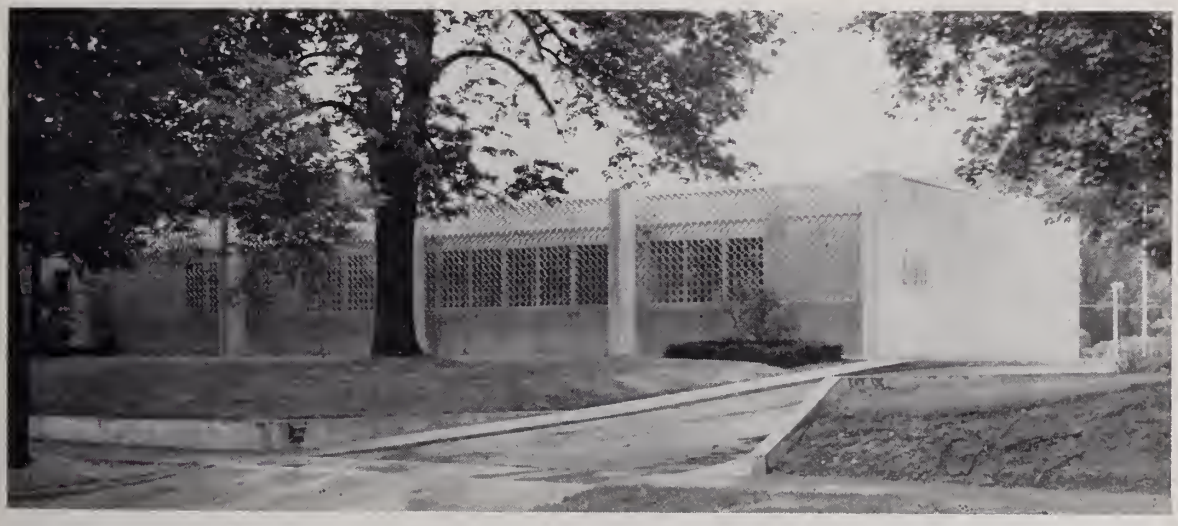
Russell L. Cecil, M.D., 81, New York City, senior editor of the Textbook of Medicine, was named as winner of the AMA's Distinguished Service Award, by the AMA House of Delegates at Chicago on June 25.

One of the nation's leading researchers in the field of arthritis, Doctor Cecil received the award at the inaugural ceremonies on June 26.

Among other award winners were Albert H. Coons, M.D., Harvard, who received the Passano Award for research, and Edwards Albert Park, M.D., Baltimore, who was awarded the 1962 Joseph Goldberger Award in clinical nutrition.

Leonard Larson M.D., Bismarck, N. D., received a plaque for his work on the medical advisory board of the Sears-Roebuck Foundation. The AMA was given awards of appreciation from the Cuban Medical Association in Exile and the Girl Scouts of America.

The AMA presented a special citation to Jackie Cooper, star of television, stage, and movies, for his portrayal of a Navy doctor in the "Hennesey" television program.



This is the headquarters office of the Indiana State Medical Association, 3935 Meridian St., Indianapolis, which was dedicated on July 15. Of contemporary design, the building contains 13,000 sq. ft. of space including meeting rooms, an office of the President, adminsitrative offices, a separate library, an office of the Journal, and sufficient room for catered luncheons.

Health Care for Aged, Medical Discipline, and Voluntary Health Insurance Among Major Issues Acted on by AMA House of Delegates*

Robert C. Long, M.D., Louisville; George P. Archer, M.D., Prestonsburg and J. Vernon Pace, M.D., Paducah, represented the KSMA at the 111th Annual Meeting of the AMA's House of Delegates in Chicago, June 24 to 28, 1962.

Also attending the House of Delegates was KSMA's president, G. L. Simpson, M.D., Greenville; chairman of the Board of Trustees, Wyatt Norvell, M.D., New Castle; and president-elect of KSMA, David M. Cox, M.D. of Louisville.

Two of the three alternate delegates, Carl C. Cooper, M.D., Bedford; and Thomas Giannini, M. D., Louisville, were present at the meeting. John C. Quertermous, M.D., Murray, was unable to attend due to the development of last minute emergencies in Murray.

The Kentucky delegation caucused three times during the meeting and these sessions were well attended by members interested in activities of the House. Doctor Archer served as a member of the Reference Committee on Rules and Orders of Business.

Health care for the aged, medical discipline, composition of the AMA Board of Trustees, a study of the American Board of Abdominal Surgery, relations with the American College of Surgeons and voluntary health insurance were among the major subjects acted upon by the House of Delegates.

Health Care for the Aged

The House received 17 resolutions expressing full support of the Kerr-Mills program and firm opposition to the King-Anderson type of legislation. In reaffirming the position of active opposition to the King-Anderson Bill, the House cited the following reasons:

"1. the lack of need for such a plan.

"2. that it would provide inadequate care for all aged rather than complete care for those who need help.

"3. the fact that inherent in the use of the Social Security mechanism are governmental controls of medical practice which would increase with the expansion of the program.

"4. deterioration of the quality of medical care not only for the aged but for the population as a whole."

In reaffirming strong support for the Kerr-Mills Act, the House declared that "the Kerr-Mills method should be given a fair and reasonable chance to meet the need and thus remove the demand for further Federal legislation."

The House took no action on one resolution which called for non-participation in the implementation of the King-Anderson Bill, but it urged individual physicians to give particular consideration to the following sections of the Principles of Medical Ethics:

"Section 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioriation of the quality of medical care."

Medical Discipline

To implement one of the major recommendations made by the Medical Disciplinary Committee at the June, 1961, meeting in New York, the House approved a change in the Bylaws under which a proposed Section 1 (B) of Chapter IV will now read:

"In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the Member belongs, or when a state medical association to which a Member belongs requests the AMA to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by AMA, the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the American Medical Association from AMA membership only for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics."

AMA Board of Trustees

The House approved a report of the Ad Hoc Committee on the Board of Trustees which recommended that the size of the Board be increased from 11 members to 15 members. This will be accomplished by adding three elected members and by including the immediate past president of the Association for a one-year term. The House also accepted a committee recommendation that set the term of office for elected Board members at three years and limited the number of terms to three, for a maximum total of nine years service. To implement the House action, the Council on Constitution and Bylaws submitted changes in the Constitution and Bylaws for consideration at the 1962 Clinical Meeting.

**Report of the KSMA delegates to the AMA.*

American Board of Abdominal Surgery

A study report from the Council on Medical Education and Hospitals, recommending that recognition should not be granted to the American Board of Abdominal Surgery as a specialty board, was approved by the House. In accepting the Council report, the House also declared its disapproval in principle of establishing specialties which are based largely or wholly on an arbitrarily defined anatomical region of the body.

The study, which was carried out under instructions from the House of Delegates at the 1961 Clinical Meeting, concluded that the present contribution of the American Board of Abdominal Surgery to the advancement of surgery and the betterment of public health is inadequate in many important respects. It also concluded that the American Board of Abdominal Surgery does not offer significant potential for the advancement of surgery and the betterment of public health.

American College of Surgeons

In considering a Board report and four resolutions involving surgical assistants and relations between the AMA and the American College of Surgeons, the House declared that the adoption and interpretation of the Principles of Medical Ethics is the prerogative and duty of the American Medical Association. It also restated the Association's June, 1961, policy statement in the following manner:

"1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"4. When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

"5. It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance. This principle applies whether or not an assisting physician is the referring doctor."

Voluntary Health Insurance

In accepting a Council on Medical Service report on the utilization of state and federal tax funds to provide voluntary prepayment health insurance protection to assist the aged in meeting the costs of health care services, the House approved the following policy statement:

"1. The need for application of the prepayment or insurance principle to protect our people against the costs of medical care is fully recognized and applies to all ages rather than to the aged alone.

"2. Persons financially able to prepay their own expenses are expected to do so and must be encouraged rather than compelled to do so.

"3. Persons financially unable to prepay adequately their expenses may properly be assisted to the degree necessary by their families, their communities, their states, and if these fail, by the Federal Government —but only in conjunction with other levels of government.

"4. The prepayment system should be devoid of governmental controls.

"5. Dignity and self-sufficiency for the individual should be upheld.

"6. The protection offered must be reasonably comprehensive rather than token in character."

The House recommended that the Board of Trustees and the Council on Medical Service explore all possibilities, using these principles as a basis.

Miscellaneous Actions

In considering reports and resolutions on a wide variety of subjects, the House also:

Learned that the Board of Trustees has instructed the Council on Drugs to conduct a study on the relationship between *tobacco and disease*.

Adopted an AMA Statement of Principles on *Mental Health* and urged all constituent associations to lend active support to the First National Congress for Mental Illness and Health, to be held in Chicago in October (see page 785).

Endorsed a resolution on *employment of the handicapped,* stating that each individual candidate for employment should be evaluated in light of his ability to perform useful work.

Approved a Guide to the Organization and Operation of *Airport Medical Services* submitted by the Council on Occupational Health.

Endorsed the joint statement on *narcotic addiction* by the AMA and the National Research Council of the National Academy of Sciences.

Seat Belts Urged

Urged automobile manufacturers to make *seat belts,* approved by the Society of Automotive Engineers, standard equipment on all automobiles.

Approved a recommendation that *AMA meetings* be scheduled as follows: Annual Meetings—1966, Chicago; 1967, Atlantic City, and 1968, San Francisco, and Clinical Meetings—1965, Philadelphia, and 1966, Las Vegas.

Recommended that the Council on Medical Education and Hospitals conduct a study of *specialty residencies.*

Reaffirmed its opposition to *compulsory coverage of physicians* under the Social Security Act, after receiving 11 resolutions opposing coverage and only two favoring the inclusion of physicians.

Accepted the report of the *Committee on Communications* as information, and, in considering the committee recommendations, suggested that the Executive Vice President present a report of Association activities to the House at each meeting.



Part of the Kentucky delegation at the AMA inaugural ceremonies at the Conrad Hilton Hotel in Chicago, Tuesday, June 26, is pictured above. Interested observers noted that the Kentucky delegation was the largest among 50 states represented at the inauguration. Front Row—Mrs. George Brockman, Greenville; Mrs. William Spalding, Louisville; Mrs. Robert C. Long, Louisville; and Mrs. Hoyt Gardner, Louisville. Second Row—Mrs. W. W. Wainer, Providence; Mrs. Guy Morford, Owensboro; Charles B. Johnson, M.D., Russell; Robert C. Long, M.D., Louisville; Mrs. Carl Cooper, Jr., Bedford; George F. Brockman, M.D., Greenville; Mrs. Charles B. Johnson, Russell. Back Row—David G. Drye, M.D., Bradfordsville; J. P. Sanford, Louisville; W. Wolf Wainer, M.D., Providence; George P. Archer, M.D., Prestonsburg; Gaithel L. Simpson, M.D., Greenville, KSMA president; Carl Cooper, Jr., M.D., Bedford; Guy Morford, M.D., Owensboro; William Spalding, M.D., Louisville; and Hoyt Gardner, M.D., Louisville.

Drug Firms Research Spending Sets New Records

New records in both research expenditures and sales volume were set by the prescription drug industry last year, according to a report by Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association, based on a survey of PMA member companies which produce about 95 per cent of the nation's prescribed medicines.

A record $245.3 million, eight per cent of sales, was spent on research and development in 1961—a 13 per cent increase over the previous year and five times as much as was spent in 1951. "The drug firm's investment in research is about triple that of the average industry," Doctor Smith said.

Research scientists and supporting staff employees during 1961 numbered 13,500, nine per cent more than 1960, with the industry leading all others in the number of trained scientists retained in ratio to other employees.

"Research budgets and estimates call for spending $268 million in 1962," Doctor Smith said. Formerly editor of the Journal of the AMA, Doctor Smith was a featured speaker at the 1962 KSMA Interim Meeting.

Dr. Rumage on AMA Committee



William T. Rumage, Jr., M.D., Louisville, has been appointed to the Committee on Disaster Medical Care of the Council on National Security of the American Medical Association.

Doctor Rumage is chairman of the KSMA Committee on Emergency Medical Service and has been active in Civil Defense work at state and county levels.

Symposium Issue Set for Oct.

"Infectious Diseases" will be the subject of the Symposium Issue of the Journal scheduled for October, according to Beverly T. Towery, M.D., Louisville, Professor and Chairman of Medicine, University of Louisville School of Medicine, special symposium editor. Six papers on various phases of the subject will make up the symposium, Doctor Towery said.

Report on the 8th Annual AMA Conference on Mental Health; AMA National Congress To Be Held October 4-6*

Logan Gragg, M.D.
Superintendent, Eastern State Hospital
Lexington, Ky.

THE Eighth Annual American Medical Association Conference on Mental Health held in Chicago, February 2-3, 1962, was devoted to consideration of the tentative platform of the AMA Council on Mental Health. The Council's platform, when approved by the Board of Trustees, would serve as the basis of the AMA program of action in the area of mental health.

Divided into Five Groups

The Conference participants were divided into five groups to consider the following topics:

1. Medical education.
2. Communicating mental health knowledge.
3. Mental health services in the community.
4. Hospital programs.
5. Personnel problems.
6. Research.

Each group submitted a report and I am sure this material will be made available to state sccieties as soon as possible.

There are some general impressions from the Conference which may be of interest to you.

The report of the Joint Commission on Mental Health and Illness, Action for Mental Health, received the general approval of the group with the recognition that it contains certain recommendations which are open to critical consideration.

There was recognition of the major roles being played in the field of mental health by both private physicians and hospitals and state mental health programs. The need was seen for expansion of private care and improvement in state programs. The interest of all physicians was felt necessary to accomplish this.

Urge All Physicians

It was urged that all physicians be more aware of and interested in the area of mental and emotional disorders and the private and public approaches to better service.

There was concern that there still exists among the laity, and also perhaps in the medical profession, the concept of "physicians and psychiatrists." It is, of course, up to psychiatrists to be a real part of medicine in general.

There was consideration of possible changes in medical education programs leading to better understanding of the "total patient."

Lack of Personnel

The lack of sufficient personnel, both clinical and research in mental health fields, was considered and long-range programs to fill these needs were suggested.

There are two very specific items from this conference which should be the concern of our State Association. The first is that there should be in every state an active committee or council corresponding to the AMA Council on Mental Health and representing the total medical profession of the State, not just the psychiatrists. This would provide a clear channel for consideration of the AMA program as it develops in this area with adaptation of the program to the specific needs of the individual states.

The second item is the proper and serious consideration of the first AMA National Congress on Mental Health scheduled for October 4-6, 1962. To this Congress will be invited a cross-section of all groups and professions interested in the field of mental health. The Congress will be expected to formulate the basis for efforts to meet the needs which exist. The leadership of the medical profession is essential in any such effort.

State Societies

It was the strong recommendation of this Conference that state societies make sure of adequate representation so that this Congress will reflect the views of the medical profession. If the Congress is dominated by other groups the statements coming from it might not indicate proper medical leadership or direction.

This Congress will be an invitational meeting and suggestions for participants are solicited from state societies. This opportunity should be utilized by submitting to the AMA Council on Mental Health the names of physicians and other representatives who can adequately participate in this meeting. A membership of some 2500 is proposed for the Congress.

**This report was submitted at the meeting of the Board of Trustees of the Kentucky State Medical Association this spring.*

128 Ky. Physicians Attend AMA's Annual Meeting in Chicago

One hundred and twenty-eight Kentucky physicians are listed by the American Medical Association as having registered at the 111th Annual Meeting of the AMA in Chicago on June 24-28.

The list of Kentucky physicians was supplied by Lloyd Prang, director of AMA membership. Physician registration at the meeting was 14,092 out of a total registration of 42,643.

Following is the complete list of Kentucky physicians attending:

Samuel M. Adams, London
E. W. Akins, Louisville
William H. Anderson, Harlan
George P. Archer, Prestonsburg
Sven A. Bach, Fort Knox
John T. Bate, Louisville
James R. Barnes, Louisville
Branham B. Baughman, Frankfort
Oren A. Beatty, Louisville
Charles F. Blankenship, Louisville
Winston Bloch, Louisville
Martin H. Boldt, Louisville
W. W. Borsch, Jr., Louisville
N. L. Bosworth, Lexington
Peter B. Bosomworth, Lexington
William E. Bowles, Louisville
George F. Brockman, Greenville
William H. Bryant, Glasgow
Ernesto M. Camacho, Madisonville
Norman K. Cohen, Louisville
Jerome Cohn, Lexington
Carl Cooper, Bedford
David Cox, Louisville
M. R. Cronen, Louisville
Leighton L. Cull, Frankfort
Irwin H. Cutler, Louisville
Joseph F. Daugherty, Florence
Pedro G. DelRosario, Harlan
Kenneth J. S. DeSimone, Louisville
David D. Drye, Bradfordsville
Stephen R. Ellis, Louisville
A. L. Embry, Millwood
M. T. Fliegelman, Louisville
J. A. Freeman, Dawson Springs
Hoyt D. Gardner, Louisville
Emery W. Garred, Catlettsburg
J. Thomas Giannini, Louisville
B. G. Giel, Lexington
Norman Glazer, Louisville
Armond T. Gordon, Louisville
Allen E. Grimes, Lexington
George M. Gumbert, Lexington
De Lou P. Hall, Louisville
John S. Harter, Louisville
Harold Haynes, Lexington
August F. W. Helmbold, Newport
John C. Hill, Louisville
Arthur T. Hurst, Louisville
Charles B. Johnson, Russell
Coleman C. Johnston, Lexington
D. L. Jones, Fulton
R. O. Joplin, Louisville
Auddie C. Kennedy, Valley Station
J. Murray Kinsman, Louisville
Zollman Kommar, Louisville
E. J. Lappat, Lexington
Lloyd O. Larsen, Lexington
Ronald L. Levine, Pleasure Ridge Park
W. Vernon Lee, Covington
Robert Lich, Jr., Louisville
Robert C. Long, Louisville
Robert T. Longshore, Covington
Marvin A. Lucas, Louisville
Ralph D. Lynn, Elkton
Dorothy Thard Magallon, Louisville
John M. Marchand, Jr., Henderson
Lloyd Dewald Mayer, Lexington
A. Clayton McCarty, Louisville
Walter F. McCrocklin, Louisville
Robert J. McGrath, Louisville
P. I. McShane, McDowell
John W. Meredith, Scottsville
Guy Morford, Owensboro
H. Reeves Morgan, Mayfield
Harold C. Morris, Louisville
Carlisle Morse, Louisville
Roy J. Mosor, Jr., South Ft. Mitchell
Patrick J. Murphy, Lebanon Jct.
Louis D. Myre, Paducah
Phillip Nodler, Louisville
Maurice Nataro, Louisville
David Neustadt, Louisville
Rudolf J. Noer, Louisville
C. Wyatt Norvell, New Castle
W. F. O'Donnell, Hazard
Walter L. O'Nan, Henderson
Earl P. Oliver, Scottsville
J. Vernon Pace, Paducah
James E. Parker, Louisville
Augustus J. Pauli, Louisville
Irving B. Perlstein, Louisville
Elliott Podoll, Louisville
Burrell Frank Radmacher, Louisville
Edward H. Ray, Lexington
Edward H. Ray, Jr., Lexington
Ben A. Reid, Louisville
Earl W. Roles, Louisville
Gradie R. Rowntree, Louisville
Marjorie Rowntree, Louisville
Russell Rudd, Fulton
Willett H. Rush, Frankfort
John J. Salter, Harlan
Samuel R. Scheen, Louisville
Charles B. Severs, Valley Station
A. A. Shaper, Louisville
G. L. Simpson, Greenville
L. H. South, Louisville
W. W. Spalding, Louisville
Robert R. Starr, Glasgow
Richard C. Stuntz, Harlan
Frank Cole Spencer, Lexington
Clarence C. Starr, Louisville
Harry J. Stone, Ashland
R. J. Timmerman, Ft. Thomas
William L. Tyler, Jr., Owensboro
Serafettin Tombuloglu, Lexington
Ruhi Turkyilmaz, Lexington
Herbert Wald, Louisville
Claude C. Waldrop, Williamstown
William R. Willard, Lexington
James F. Williamson, Louisville
Herman Wing, Louisville
Carroll L. Witten, Louisville
Paul A. Wolf, Louisville
Charles Wood, Auburn
William E. Yancey, Louisville
Frank L. Yarbrough, Owensboro
Nen K. Yong, Lexington

New KSMA Members

The following new members have joined the Kentucky State Medical Association: John J. Salter, M.D., and Frank B. Gross, Jr., M.D., both of Harlan; Alvin J. Summar, M.D., Lynch; Joel Leonard, M.D., Leatherwood; J. D. Lewis, M.D., Mt. Vernon.

From Ashland: Evalyn Evans, M.D.; M.P. Nido, M.D.; S. A. Shaffer, M.D.; Charles Webb, M.D.; Joe Wheeler, M.D. Also J. E. Esteves, M.D., Warsaw; Robert L. Hast, M.D., and Lloyd E. Deddens, M.D., both of Owensboro; C. R. Gill, M.D., Lexington; Charles K. Sergeant, M.D., Louisville; Lyle C. Franz, M.D., Maysville, and Jim B. Tolliver, M.D.. Whitesburg.

The Ninth Annual Meeting of the Academy of Psychosomatic Medicine will be held November 1-3, 1962, at the Radisson Hotel, Minneapolis, Minn. The goals of the Academy and its journal "Psychosomatics," are to further the integration of medicine and psychiatry so that doctors, irrespective of their specialty or type of medical practice can better understand and treat their patients.

Ridge Michael Sly, M.D., has been appointed chief resident in pediatrics at the University of Kentucky Medical Center. Doctor Sly was born in Seattle, Wash., and received his medical degree from Washington University in 1960. He interned and took residency training at St. Louis Children's Hospital.

KSMA Council, Committee Reports

Highway Safety Committee

Arthur H. Keeney, M.D., Chairman

Headquarters Office Bldg., Louisville **June 28, 1962**

The KSMA Committee on Highway Safety met June 28 in the Headquarters Office Building, Louisville.

A discussion was held on the seat belt campaign and the survey which was made in 1961 in Christian and Jefferson counties. Doctor Keeney reported on the Kentucky-Cornell Automotive Crash Injury Research Program. The program will start in Kentucky August 1.

In addition the committee discussed the recent meeting of the Legislative Research Council Advisory Committee on Highway Safety; visual screening of the State Division of Driver Licensure; driver limitation as a reportable disease; a resolution for federal safety standards; KSMA awards to groups for 100 per cent seat belt use; and an exhibit of the State Department of Public Safety at the 1962 Annual Meeting.

Plans were made to hold a press conference in relation to the Kentucky-Cornell program. William T. Rumage, Jr., M.D., and Mr. Judson Edwards, State Department of Public Safety were guests of the committee.

Insurance Committee

John Dickinson, M.D., Chairman

Headquarters Office Bldg., Louisville **June 7, 1962**

The KSMA Insurance Committee met for the first time this year Thursday, June 7, in the Headquarters Office Building, Louisville.

Several guests from the Kentucky Hospital Association, the Kentucky Association of Registered Nurses, the Health Insurance Council, the State Department of Insurance and an Insurance Company, and others attended the meeting.

Mr. Hasty Riddle, executive secretary, Kentucky Hospital Association, gave the committee some background information on the preparation of a Guide for Release of Information From Medical Records.

Doctor Dickinson called on other guests to give their viewpoint regarding the release of information from medical records. The committee commended the KHA for its work in reference to this Guide.

The committee discussed an insurance committee questionnaire, health insurance claims forms and a letter from Gaithel L. Simpson, M.D., president of KSMA.

Emergency Medical Services Committee

William T. Rumage, Jr., M.D., Chairman

Headquarters Office Bldg., Louisville **May 31, 1962**

The Emergency Medical Services Committee held its third meeting this year Thursday, May 31, in the KSMA Headquarters Office, Louisville.

The committee had as its guests Charles Leneave, M.D., Louisville, and Mr. Forrest Stokes, USPHS, Frankfort. Doctor Leneave was present to explain how the Kentucky Flying Physicians Association could be of assistance in the time of a disaster.

Doctor Rumage reported on the Regional Workshop Session he attended on Disaster Medical Care in Pittsburgh May 11-12. The Workshop was sponsored by the AMA. In addition the committee discussed the progress of the medical self-help training program; special issue of KSMA Journal dealing with civil defense; and the setting up of a 200-bed emergency mobile hospital at the 1962 annual meeting.

Diabetes Committee

Robert S. Tillett, M.D., Chairman

Headquarters Office Bldg., Louisville **June 20, 1962**

The KSMA Diabetes Committee held its first meeting during the associational year June 20, in the KSMA Headquarters Office Building, Louisville.

Doctor Tillett gave a report on the past ten KSMA Diabetes Detection Drives and the committee outlined the promotion of the 1962 Drive.

Kenneth Crawford, M.D., and Armond T. Gordon, M.D., and Mr. Eldon Kronewitter, State Department of Health, Frankfort, were guests of the committee.

School Health Committee

R. E. Davis, M.D., Chairman

Campbell House, Lexington **June 14, 1962**

The third meeting of the School Health Committee during the associational year was held Thursday June 14, at the Campbell House in Lexington.

The committee formulated plans for a symposium on athletic medicine and an exhibit in the KSMA Scientific Exhibit Section during the 1962 KSMA annual meeting. The committee also drafted a resolution on physical education to be presented to the KSMA House of Delegates.

Mr. Joe Mansfield, representing the Kentucky High School Athletic Association, was a guest of the committee and participated in the discussion of the planning of regional Athletic Injury Prevention Conferences.

MSEA Elects Sanford

The Medical Society Executives Association, an organization of some 250 members, has elected KSMA's Executive Secretary, Joseph P. Sanford, to its Board of Directors. The Association is composed of staff people working for medical associations at the county, state, regional, and national levels.

One of the association's prime objectives is to devise an effective method of training new people both before they enter the work and in service. Mr. Sanford, who was elected at the association's meeting held during the recent AMA Annual Meeting, also serves on two of its committees.

Cancer Grant Goes To U.K.

The American Cancer Society has awarded $20,000 to the University of Kentucky for use as an Institutional Research Grant. Purpose of the grant is to encourage new minds and ideas to enter cancer research. A committee of U. of K. scientists, headed by Wellington B. Stewart, M.D., as chairman, has been appointed to administer the grant.

Dr. Gershon-Cohen To Visit U.K.

On October 11, J. Gershon-Cohen, M.D., assistant professor of radiology of the Graduate School of Medicine of the University of Pennsylvania will visit the department of radiology at the University of Kentucky. Doctor Gershon-Cohen, who is also a radiologist at the Albert Einstein Medical Center, Northern Division, Philadelphia, will speak at the Medical Center that evening on "Mammography."

He received the Gold Medal Award from the International College of Radiology in 1937, and has done extensive research on radiology of the gastro-intestinal tract, cancer and pulmonary tuberculosis. Within the past several years he has perfected and popularized x-ray examination of the breast. His techniques have led to the discovery of early carcinoma of the breast, in some cases before the lesions are palpable on physical examination.

Dr. Falkner Going to Africa

Frank Falkner, M.D., chairman of the University of Louisville Department of Pediatrics, will fly to Nigeria in November to help plan Africa's newest and largest children's hospital. He will be working with Robert Collis, M.D., an Irish physician and author who has worked there for the past four years.

Together they will lay plans for a new 200-bed children's hospital at the University of Lagos. The hospital will be built partly with funds from private United States foundations. Both Doctor Falkner and Doctor Collis, who are old friends, will also consult on a series of world-wide studies which are being conducted in eight nations on growth nutritional problems.

U.S.P.H.S. Names Dr. Rasor

Robert W. Rasor, M.D., previously medical officer in charge of the U. S. Public Health Service Hospital at Ft. Worth, Texas, has been appointed medical officer in charge of the U. S. P. H. S. Hospital in Lexington. He replaces Murray A Diamond, M.D., who will devote full time to his duties as assistant surgeon general of the Public Health Service, in charge of all PHS personnel policies.

Warren P. Jurgensen, M.D., is also being transferred from the Ft. Worth hospital to become deputy medical officer in charge. He replaces James F. Maddux, M.D., who has been appointed medical officer in charge at Ft. Worth.

Dr. Witten Speaks To AMA

Carroll L. Witten, M.D., Louisville, spoke before the EENT group during the Annual Meeting of the American Medical Association. His topic was "Nose Bleed."

Correction

The Journal staff wishes to apologize for the misspelling of the McCormack name in the Dedication Section of the April, 1962 Journal of KSMA.



Adding a bit of historical interest as well as utilitarian value to the site of the new KSMA headquarters office building is this sign located just west of the Board Room facing Janet Avenue. It is the original plaque which was on the front of the headquarters when it was located at the State Board of Health Building at 620 South Third Street, Louisville, and was used as a marker on that building for nearly 20 years until the move to the Medical Arts Building in 1957. Louisville sign makers have estimated that a similar bronze sign would cost more than $950 today.

Pediatrics Course Planned

The Department of Pediatrics of the University of Kentucky Medical Center announces a monthly post-graduate program to be held from one to four p.m. on the first Friday of each month beginning in October. Each session will comprise: (1) rounds with presentation of cases, (2) a formal discussion of a basic science subject related to pediatrics and, (3) separate seminars in various pediatric sub-specialties including hematology, allergy, cardiology, metabolism, neurology, and problems of the newborn.

The program, which is being submitted for KAGP general practice credit, will be open to general practitioners, pediatricians, and others whose major medical interests include problems of infancy and childhood. Interested physicians are asked to write John H. Githens, M.D., Department of Pediatrics, University of Kentucky Medical Center, Lexington, Ken-

Foundation Announces Grants

The Louisville Foundation has announced three grants totaling $34,000. The grants include $25,000 toward the planned Child Psychiatry Study Center of the University of Louisville School of Medicine. That amount will go toward matching federal money being sought for the $221,327 facility in the Medical Center.

The other grants were: $5,000 to the Rehabilitation Center for its $650,000 building-fund campaign and $4,000 to Bridgehaven, Inc., a facility to help former mental patients readjust to normal life.

Int. Coll. of Surgeons to Meet

The International College of Surgeons 13th Bienniel Congress will be held at the Waldorf-Astoria Hotel, New York, on September 9-13. About 3,500 surgeons from over the world are expected to attend.

The Congress will include a general assembly program and specialty group programs. Edward R. Annis, M.D., Miami, Fla., will be the principal speaker at a banquet on Wednesday, September 12.

OPPORTUNITIES

From The

KSMA Postgraduate Medical Education Office

Visiting Clinics in Rural Areas Conducted by PG Office

A series of six conducted clinics at selected hospitals throughout the State is scheduled for the summer months, according to the KSMA Office of Postgraduate Medical Education. Three clinics have already been held and the program so far has been well received.

Purpose of the visiting clinics, sponsored by the KSMA PG Office, the University of Louisville School of Medicine, and the University of Kentucky College of Medicine, is to bring the latest University medical information to rural areas.

First three visiting clinics were held in Corbin, Scottsville, and Shelbyville. Another is scheduled for Pikeville sometime between August 15 and 31. Two other visiting clinic sites will be selected in the near future.

Clinics include presentation of problem patients and discussion of records, charts, x-rays, and other clinical data presented by local physicians. Each clinic is conducted by a representative from each of Kentucky's medical schools.

Those conducting the first three clinics have included: Maurice Best, M.D., Beverly Towery, M.D., Leonard Leight, M.D., all of Louisville; and Edmund D. Pellegrino M.D., Richard Crutcher, M.D., John T. Reeves, M.D., and Harold D. Rosenbaum, M.D., all of Lexington.

In Kentucky

AUGUST

19	KAGP Seminar, Lexington, Kentucky.
23	KAGP Seminar, Diamond Caverns Hotel, Park City, Kentucky.

SEPTEMBER

6	Postgraduate Course, "CARDIOVASCULAR SURGERY, INDICATIONS, TECHNIQUES, and RESULTS," University of Kentucky Medical Center, Lexington, Kentucky.
18-20	KSMA Annual Meeting, Columbia Auditorium, Louisville, Kentucky.

OCTOBER

3	Postgraduate Course, "ANESTHESIOLOGY—SPECIAL EMPHASIS FOR GENERAL PRACTITIONERS," Louisville General Hospital, Louisville, Kentucky.
4	KAGP Seminar, Henry Clay Hotel, Ashland, Kentucky.
Oct. 5	Monthly Postgraduate course—Pediatrics, University of Kentucky Medical Center, 1-4 p.m. This course will continue to be held the first Friday of each month.
5-6	Postgraduate Course, "THE EARLY ORIGINS OF DISEASE IN CHILDREN AND THEIR IMPLICATIONS AND MANAGEMENT," University of Kentucky Medical Center, Lexington, Kentucky.
10	Lexington Clinic, Lexington, Kentucky.
10, 17, 24, 31	Jefferson County Chapter Academy of General Practice, Fall Seminar, Louisville, Kentucky.
11	"Mammography," J. Gershon-Cohen, M. D., 7:30 p.m., University of Kentucky Medical Center, Lexington, Kentucky.
18	KAGP Seminar, Maysville, Kentucky.
25	Kentucky Rural Health Conference, Cumberland Falls, Kentucky.

Surrounding States

AUGUST

23-25	West Virginia State Medical Association, White Sulphur Springs, W. Va.
29-30	Postgraduate Institute: Medical Aspects of High School Athletics, Ohio State University, Columbus, Ohio; advance registration only; write: Hart F. Page, OSMA, 79 E. St., Columbus, Ohio.

SEPTEMBER

19-21	Postgraduate Course, "Basic Electrocardiography," Indiana University, Indianapolis, Indiana.
24 thru Oct. 6	PG Course in Laryngology and Bronchoesophygology, Univ. Illinois, College of Medicine, 1853 W. Polk St., Chicago 12.

Cook County Graduate School of Medicine, Chicago, Ill., has various courses during September, information on request.

OCTOBER

1-4	Interstate Postgraduate Medical Association of North America, Palmer House, Chicago, Illinois.
22-23	American Cancer Society Annual Session, New York, New York.
26-28	American Heart Association Annual Meeting, Cleveland, Ohio.
29-November 1	American Academy of Pediatrics Annual Meeting, Chicago, Illinois.

Cook County Graduate School of Medicine, Chicago, Ill., has various courses during October, information on request.

Dr. John Walton Honored

John P. Walton, M.D., Muhlenberg County physician for 54 years, was honored at a testimonial dinner of the Central City Business and Professional Women's Club on June 22. The club designated him "Boss of the Year" and also elected him to honorary lifetime membership and presented him with a commission as Colonel on the Staff of Governor Bert Combs. Civic clubs, other physicians and City and County government leaders were present at the dinner.

Doctor Walton graduated from the U. of L. School of Medicine in 1906. He practiced briefly in Denver, Col., then returned here in 1908. Muhlenberg Countians credit him with typifying the best of the old-time country doctor, while always keeping abreast of medical advances.

M.D.s Asked To Check Old Books

A special Committee of Sixty has been formed by Hoyt Gardner, M.D., to assist in restoring and obtaining items of special historical interest for the Kornhauser Memorial Medical Library of the University of Louisville School of Medicine. Their first purchase was Daniel Drake's Notes on Cincinnati, 1813. If any physician has material pertaining to the old Library or that could have been from it, he is asked to contact Dotor Gardner, a member of the committee, or Miss Joan Titley the librarian.

Miss Titley further asks that anyone who owns books printed before 1846 check to see if the books contain an old bookplate from the Louisville Medical Institute Library of 1837-46. Three such books lost during the past 125 years have recently been found and returned home.

Dover A. Dick, M.D., has begun practice in Berea in association with **E. T. Hays, M.D.**, and **C. F. Kerby, M.D.** Doctor Dick received his medical degree from the University of Cincinnati in 1926 and interned at Tripler Army Hospital, Honolulu. He served for five years as a pilot and two years in the medical corps of the Air Force where he held the rank of captain.

D. C. Cameron, M.D., a native of Myers, Ky., has opened an office for the general practice of medicine in Owingsville. A 1959 graduate of the University of Cincinnati Medical School, Doctor Cameron interned at St. Joseph Hospital, Lexington.

A 1959 graduate of the University of Louisville School of Medicine, **Norman E. White, M.D.**, has begun general practice in Central City. Doctor White interned at Kentucky Baptist Hospital, Louisville, and served for two years in the Air Force. He has had a previous practice in Millersburg.

Morris M. Weiss, Jr., M.D., has begun a practice limited to cardiology in association with **Morris M. Weiss, Sr., M.D.**, Louisville. Doctor Weiss received his medical degree from the University of Louisville in 1958 and interned at the Pennsylvania Hospital. In 1959 he was a Fellow in Hypertension at the University of Pennsylvania Hospital. He then became assistant resident in medicine at the Barnes Hospital of Washington University.

County Society Reports

Muhlenberg County

At its monthly meeting on July 9, the Muhlenberg County Medical Society recommended that the trustees of the Muhlenberg Community Hospital consider the establishment of an Adjunct Dental Staff.

A report on the American Medical Association was given by KSMA president Gaithel L. Simpson, M.D. The Society adopted a resolution commending the AMA for its stand in opposition to King-Anderson type legislation and also voted against having Social Security coverage extended to physicians themselves.

The scientific portion of the meeting was devoted to the study of the diagnosis and treatment of various forms of cerebral vascular accidents.

New KSMA Members Told

New members of the Kentucky State Medical Association include the following: Wallace Combs, M.D., Nicholasville; Robert D. Eastridge, M.D., Murray; Dallas Hagg, M.D., and M. Stuart Lauder, M.D., both of Frankfort, and the following from Lexington: John Githens, M.D.; R. H. Greenlaw, M.D.; Rudolph Muelling, M.D., and W. W. Winternitz, M.D.

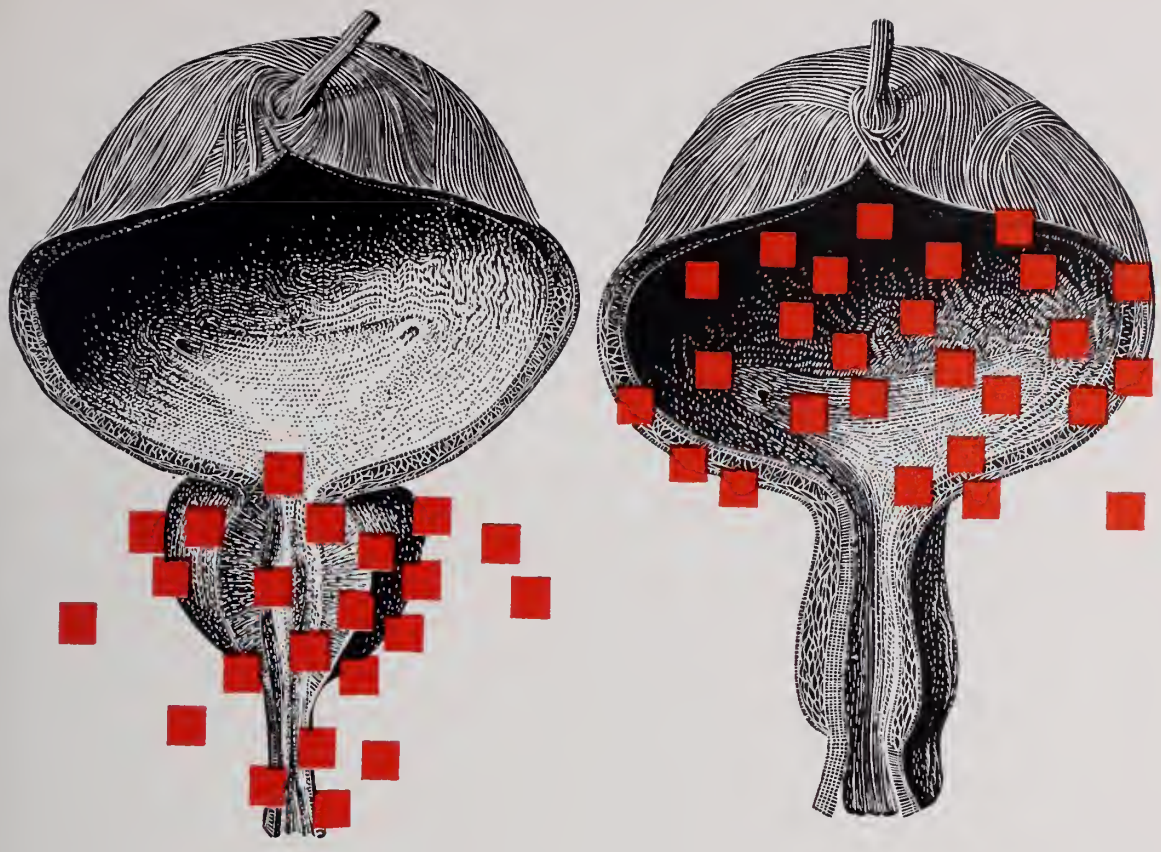
A native of Oak Park, Ill., **Roy M. Slezak, M.D.**, has begun the practice of obstetrics and gynecology in association with **Harper Wright, M.D.**, at the Graves-Gilbert Clinic, Bowling Green. Doctor Slezak, a 1955 graduate of the University of Illinois Medical School, interned and took residency training at Swedish Hospital, Seattle, Wash. He did further residency work at Madigan General Hospital, Tacoma, Wash. Doctor Slezak served as a major in the Medical Corps for five years.

Thomas M. Wilson, M.D., who has practiced in Minot, N. D., for the past two years has joined **R. N. McLeod, Jr., M.D.**, Somerset, in a practice limited to pediatrics. Doctor Wilson is a 1957 graduate of the University of Tennessee Medical School. He interned at Baptist Hospital, Nashville, Tenn., and took residency training in pediatrics at the same hospital.

Frederick J. Cecil, M.D., Horse Cave, has gone to the Veterans Hospital at the University of Miami where he will undertake a four-year study of surgery. Doctor Cecil, a graduate of the University of Louisville School of Medicine, has practiced in Horse Cave since January 1956.

Central City physician **James N. Tulloh, M.D.**, has moved to Fort Worth, Texas, where he will take his residency in anesthesiology at Harris Hospital.

Kenneth E. Lanter, M.D., who has practiced medicine in Florence for the past five years, has made plans to do three years of post-graduate work in psychiatry at the University of Louisville School of Medicine. He received his medical degree from the U. of L. in 1956.



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News Of The Profession In and About Kentucky

Harry C. Denham, M.D., Maysville, has been appointed by Governor Bert Combs as a member of the University of Kentucky Board of Trustees. Doctor Denham is an alumnus of the University and currently is serving as president of the alumni association. He has served the U. of K. once before on the Board from 1955 to 1957. His new term will expire December 31, 1965.

Gabe A. Payne, Jr., M.D., announces that he is resuming his medical practice in Hopkinsville. Doctor Payne, who has been serving as director of the pediatrics clinic at Vanderbilt Hospital, Nashville, Tenn., during the past year, will limit his Hopkinsville practice to pediatrics.

V. A. Jackson, M.D., who has been in practice in Clinton, Ky., for the past 17 years, has moved to Lexington where he has opened an office for general practice. Doctor Jackson is a graduate of the U. of L. School of Medicine.

Delmas M. Clardy, M.D., Hopkinsville; **David G. Miller, Jr., M.D.,** Morgantown; and **Travis B. Pugh, Jr., M.D.,** Bowling Green, were among 30 uncompensated and compensated personnel of the Kentucky Selective Service System who were honored at a 20-Year Banquet held June 18 in Frankfort. They served under the Selective Training and Service Act of 1940 until its expiration on March 31, 1947. When the Universal Military Training and Service Act was enacted in 1948, each was again selected to be a medical adviser.

Kenneth E. Lanter, M.D., Florence, has received a scholarship from the National Institute of Mental Health for three years of specialized training in psychiatry at the University of Louisville School of Medicine. Vice president of the Boone County Medical Society and a member of the Board of the Northern Kentucky Mental Health Association, Doctor Lanter will serve on the teaching staff of the U. of L. Medical School and on the consulting staffs of several Louisville area hospitals. Until his return to Florence, his practice will be taken over by Philip B. Schworer, M.D. Doctor Schworer graduated from the University of Cincinnati Medical School two years ago and has been practicing in South Fort Mitchell.

John C. Davenport, M.D., who has been practicing in Paris, has moved to Anaheim, Calif., where he is opening an office for general practice. Doctor Davenport is a 1959 graduate of the University of Louisville School of Medicine.

John Hall, M.D., who has been practicing medicine in Scottsville since last August, has entered the U. S. Army Medical Service. Doctor Hall graduated from the University of Louisville School of Medicine in 1960 and served a rotating internship at the Medical Center, Columbus, Ga. He will be stationed at Fort Benning, Ga., and plans to return to Scottsville to practice following his two years of service with the Army.

Glenn R. Noss, M.D., who received his medical degree from the University of Tennessee in 1953, has begun general practice in association with **Charles W. Harting, M.D.,** and **James C. Embry, M.D.,** of the **West McCracken County Clinic,** Heath, Ky. He interned at Crawford Long Hospital, Atlanta, Ga. Doctor Noss, who served for two years with the U. S. Army during World War II, has been an industrial physician with Union Carbide Nuclear Co., Paducah, for the past seven years.

James I. Huddleston, M.D., has received a commission in the United States Public Health Service with the rank of surgeon. A graduate of the University of Louisville School of Medicine, Doctor Huddleston has just completed his internship at Louisville General Hospital. He has been assigned to the hospital at Terminal Island, Long Beach, Calif.

Charles F. Martin, M.D., who has been a physician at International Business Machines, Lexington, since 1957, has been transferred to the IBM plant at White Plains, N. Y. Before joining IBM, Doctor Martin had practiced in Winchester for five years. A graduate of the University of Louisville School of Medicine, he has been a clinical assistant professor, department of community medicine, at the University of Kentucky College of Medicine since 1961.

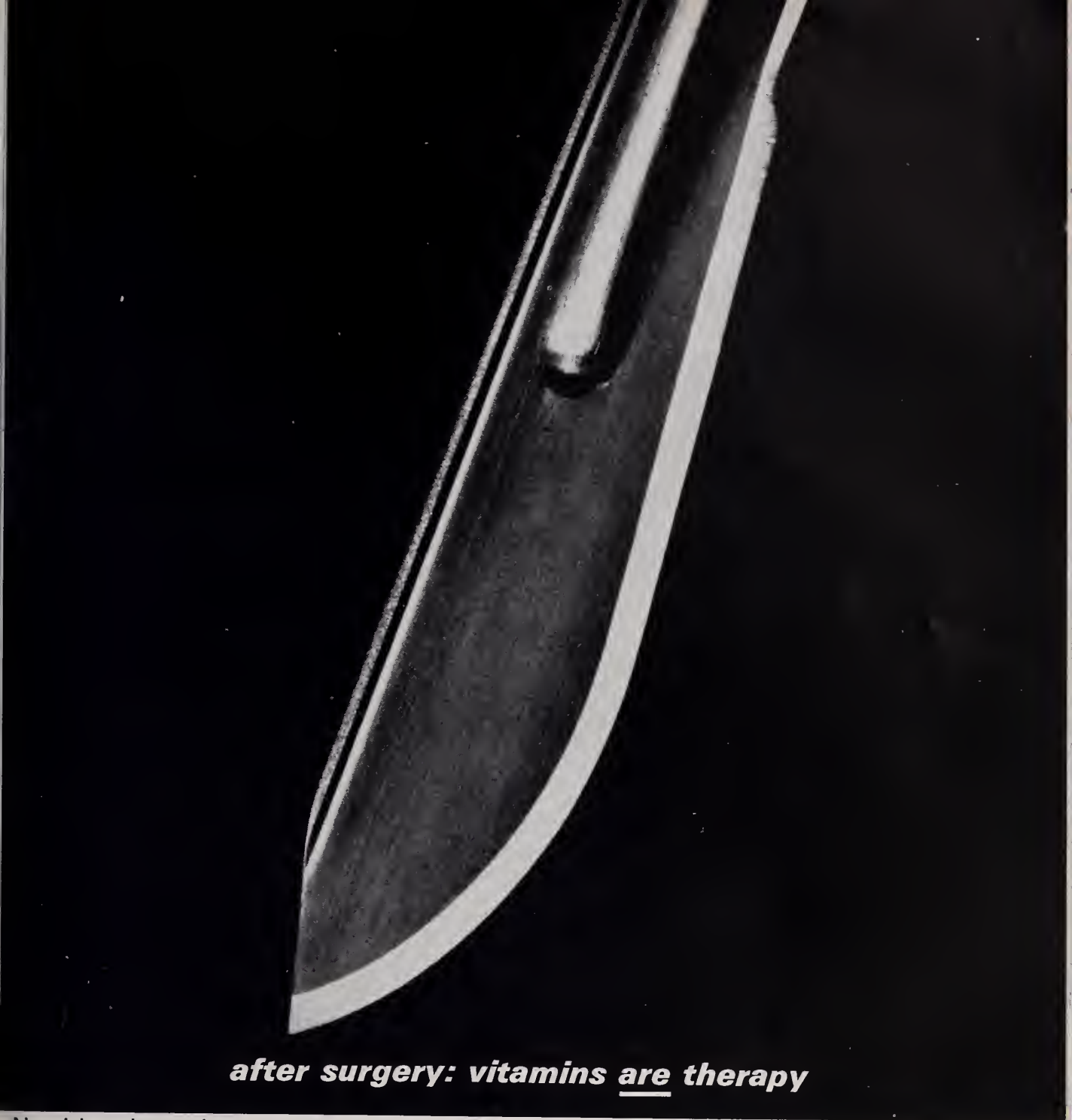
The University of Kentucky has presented a distinguished alumnus award to **Ralph J. Angelucci, M.D.,** Lexington, class of 1934. Doctor Angelucci, who later received his medical degree from the Vanderbilt University School of Medicine in 1938, was cited for service to his community as well as to the University of Kentucky.

Charles C. Smith, M.D., has joined **Jerry M. Shaw, M.D.,** Louisville in a practice limited to internal medicine. Doctor Smith is a 1955 graduate of the University of Louisville School of Medicine and interned at University Hospital and Hillman Clinic, Birmingham, Ala. After serving two years in the Air Force, he completed a residency in internal medicine at the University of Louisville hospitals. For the past year he has been a full-time member of the faculty at the U. of L.

A 1961 graduate of the Albert Einstein Medical School, **Joseph Book, M.D.,** is now practicing general medicine in association with the Miners Memorial Hospital, Middlesboro. Doctor Book, a native of Brooklyn, N. Y., interned at Cincinnati Jewish Hospital.

Edwin T. Thorsness, M.D., retired June 30, from the position of pathologist and director of the clinical laboratories of the Methodist Hospital, Pikeville. Doctor Thorsness, who joined the hospital staff in October 1955, has planned to make his future home at Michigan North Woods Club, Ishpening, Mich.

Lee H. Vensel, M.D., formerly associated with **L. F. Beasley, M.D.,** Franklin, has accepted a residency in pediatrics at Mid-State Hospital, Nashville, Tenn. The appointment is for two years.



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Niacinamide	100 mg.
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Vitamin B_{12} Crystalline	4 mcgm.
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In Memoriam

ANDREW J. BRYSON, M.D.
Ashland
1880-1962

A retired Ashland physician and surgeon, Andrew J. Bryson, M.D., died June 24. Doctor Bryson received his medical degree from the Kentucky School of Medicine in 1906 and returned to his native Greenup County where he began practice at South Shore. He moved to Ashland in 1916 and practiced there until his retirement a year ago.

A member of the Boyd County Medical Society and the Kentucky State Medical Association, Doctor Bryson was 82 and had been ill for the past year.

JOSEPH EMORY JENKINS, M.D.
Sebree
1887-1962

Joseph Emory Jenkins, a general practitioner at Sebree for 50 years, died June 23 at Methodist Hospital in Henderson. He was 74. Doctor Jenkins began his medical practice at Onton in 1912 after his graduation from the Medical Department of the University of Louisville.

Last fall Doctor Jenkins was honored by his community when he was crowned "Mr. Sebree."

RAYMOND NEW HOLBROOK, M.D.
Louisville
1901-1962

Raymond New Holbrook, a general practitioner in Louisville for 28 years prior to his retirement seven years ago, died at St. Joseph Infirmary on July 18. Since his retirement he had operated the Southern Medical Laboratory, Louisville.

A graduate of the University of Louisville School of Medicine in 1926, he practiced in Shepherdsville for about two years before coming to Louisville. He gave up his general practice after suffering a stroke seven years ago.

L. A. CRUTCHER, M.D.
Louisville
1882 - 1962

L. A. Crutcher, 79, Louisville, general practitioner in the West End of the city for more than 50 years, died at SS. Mary & Elizabeth Hospital June 11.

Doctor Crutcher retired from active practice two years ago. He was graduated in medicine from the Medical Department of Kentucky University, Louisville, in 1906.

CHARLES K. BROSHEER, M.D.
Middlesboro
1873-1962

Charles K. Brosheer, M.D., Middlesboro physician and surgeon for over 50 years, died June 23. He was born in Quincy, Ill., and came to Middlesboro in 1891. He received his medical degree from the University of Nashville in 1900 and returned to Middlesboro where he became a co-founder of the Middlesboro Hospital in 1919.

Doctor Brosheer has served as president of the Bell County Medical Society, a member of the local school board and a director of the Middlesboro National Bank and the Middlesboro Daily News. He was 89.

JOHN MILTON REES, M.D.
Cynthiana
1872-1962

J. M. Rees, M.D., a lifelong resident of Harrison County, died July 3 at the Harrison Memorial Hospital where he had been a patient since April 5. Doctor Rees began practice in Cynthiana in 1895 and remained active until his recent illness.

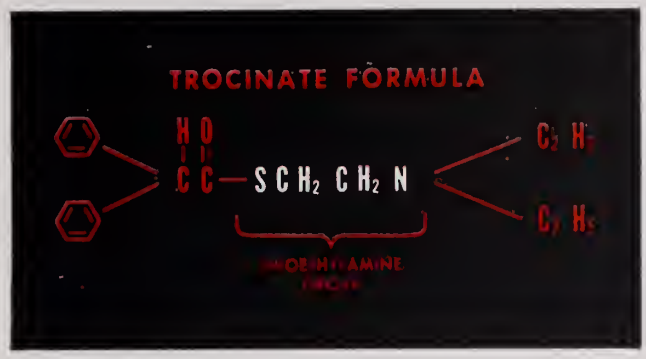
He graduated from the Medical College of Ohio, Cincinnati, in 1895 and took graduate work at the University of Chicago in 1912 and at New York University in 1921. He was one of the founders of the hospital that later became the Harrison Memorial Hospital.

EDGAR STANLEY McILVAIN, M.D.
Cynthiana
1879-1962

A retired Cynthiana physician who had been in ill health several years, Stanley McIlvain, M.D., died June 29 at Peebles Nursing Home. Doctor McIlvain was born in Harrison County and received his medical degree from Vanderbilt University School of Medicine, Nashville, Tenn., in 1905. He was 83.

LEWIS A. OATES, M.D.
Veachland
1879-1962

A resident of White Plains for many years, Lewis A. Oates, M.D., died May 31 at the Masons Home at Veachland where he had lived for the past three years. Doctor Oates, who was 86, was a 1904 graduate of the Hospital College of Medicine, Louisville. He began practice in the area from Nortonville to Mannington after graduation and remained there until his retirement in 1955.



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Washington News

(Continued from Page 724)

1961 has inreased by small amounts the normal risks of adverse health effects."

The report said radiation doses from all nuclear tests through 1961 "have generally been a small fraction" of the amount received from natural radioactive sources such as radium in the earth's crust, cosmic radiation from space, and carbon-14 and potassium-40 in the human body.

Basing its estimates on measurements of radioactive particles in air, rain, soil, water supplies, food and human bodies, the Council said the dose from all atomic tests through 1961 was from one-tenth to one-quarter of the amount received from the natural background.

Harold E. Resinger, M.D., a pathologist who has previously practiced in Des Moines, Iowa, has begun practice in Lexington at Good Samaritan Hospital. Doctor Resinger has been certified by the American Board in Clinical Pathology and Anatomical Pathology. He received his medical degree from the University of Nebraska in 1954 and interned at Nebraska Methodist Hospital, Omaha. He took residency training at Mercy Hospital, Des Moines, Iowa.

A former Kuttawa, Ky., physician, **John E. Cotthoff, M.D.,** has opened an office for the practice of internal medicine, following the completion of his specialty training, in Hopkinsville.

A survey by the American School Health Association discloses that the nation's school children are receiving far from uniform protection against tuberculosis, despite the availability of "effective eradication procedures." In order to alert educators to the "urgent need" for uniform tuberculosis screening, the Association is distributing the results of its survey in compendium form to school heads in each state including Puerto Rico and the District of Columbia. Copies of "A Compendium of State Regulations and Recommendations Concerning Tuberculosis Screening of School Children" may be obtained from the Association's executive secretary, Dr. A. O. DeWeese, American School Health Association, 515 East Main Street, Kent, Ohio.

Frank B. Gross, Jr., M.D., has begun practice at the Harlan Memorial Hospital where he limits his practice to internal medicine. Doctor Gross, a native of Des Moines, Iowa, has previously practiced in Asheville, N. C. He received his medical degree from Bowman Gray Medical School in 1945 and interned at St. Louis University. He took residency training at the North Carolina Baptist Hospital and Duke University.

John C. Davenport, M.D., Paris, has closed his office of general medical practice and has moved to California. Doctor Davis began a practice in Garden Grove, Calif., in July in association with three other physicians there. A 1959 graduate of the University of Louisville School of Medicine, he began practice in Paris in July 1960.

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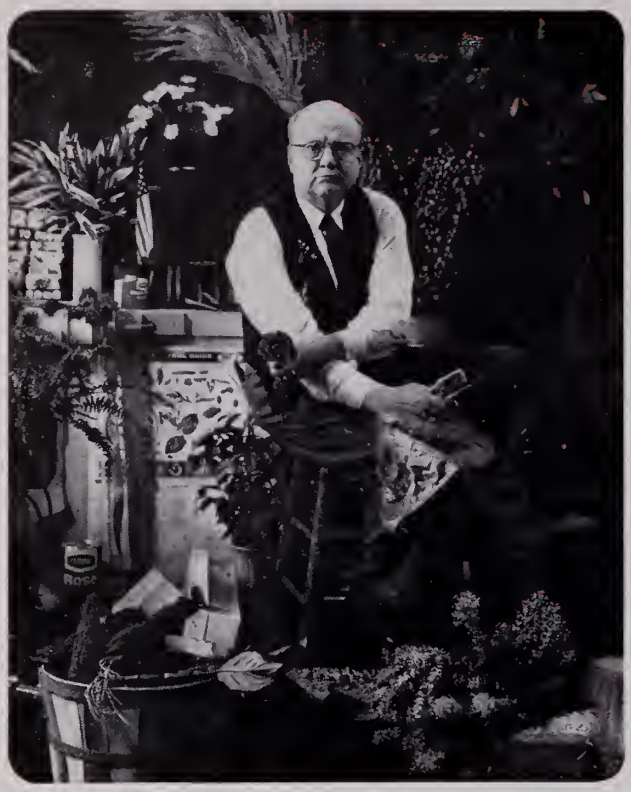
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PHARMACEUTICALS RESEARCH

NEWS ITEMS

O L. Avery Jr., M. D. Bowling Green, who was associated in practice with the late Samuel E. Paris, M.D., will continue his practice at the same location, 831 State St., Bowling Green.

R. W. Bushart, M.D., Fulton; **Paul B. Hall, M.D.,** Paintsville; **H. B. Murray, M.D.,** West Liberty; **Ralph Angelucci, M.D.,** and **Francis Massie M.D.,** both of Lexington, have been named to a 60-member citizens committee to set long-range goals for the University of Kentucky and to determine the ways of reaching those goals.

Effect of compulsory generic name use on the ethical drug makers would be profound, say industry spokesmen. Gone would be the incentive to make the highest possible quality products; minimum standards would suffice. The incentive to improve existing drugs would disappear. There would be little incentive to develop dosage forms which could benefit relatively few people, and there would be little incentive to distribute a product to areas where statistics show sales would be relatively low. The most expensive drug is the one you can't get when you need it . . . And incentive and money to do research toward new drugs to lick the as yet incurable diseases would be lacking. The question then arises: Where would tomorrow's drugs come from?—*Chemical & Engineering News,* June 13, 1960.

James N. Tulloh, M.D., in general practice at Central City for four and one-half years, has closed his office and gone to Harris Hospital at Ft. Worth, Texas, for a two-year residency in anesthesia. Doctor Tulloh was graduated from the University of Louisville School of Medicine in 1955.

Charles J. Corea, M.D., has entered general practice with the Cumberland Clinic at Cumberland, Ky. Doctor Corea, a native of Ludlow, Ky., was graduated from the University of Tennessee College of Medicine in 1961 and interned at the City of Memphis Hospital. He served in the U. S. Army in 1954-1956.

"There is no person alive who can take a bottle of pills, look at them, feel them, smell them and taste them and tell you whether or not they are of high quality. We all know that most people can pretty well determine the quality of textiles and experts can tell exactly what the quality is by using ordinary senses. This is not so with drugs. I repeat—the only way you can reasonably judge the quality of a drug is by relying on the reputation of the name on the label."—Joseph E. Snyder, M.D., assistant vice president, New York Presbyterian Hospital, to the American Hospital Association.

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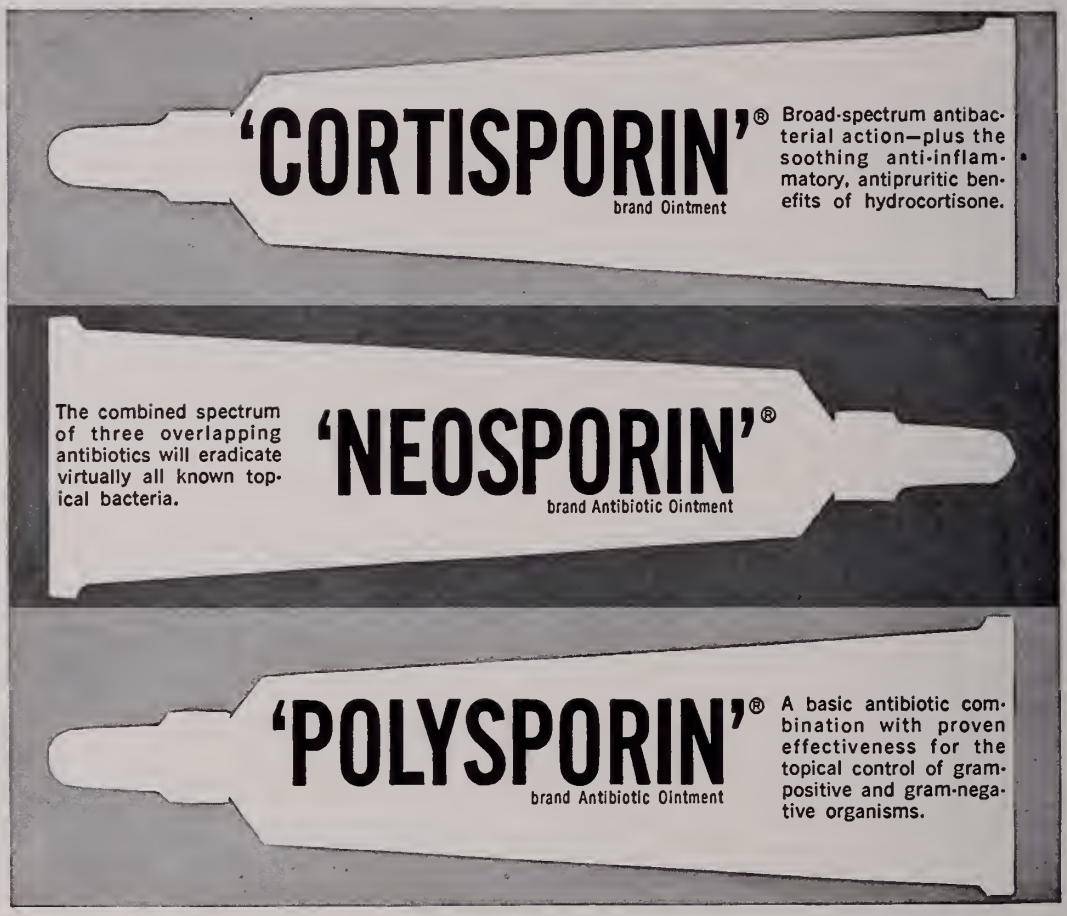
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Pertinent Paragraphs

William E. Bond, M.D., anesthesiologist at Ashland, Ky., has moved to Columbus, Ohio. Doctor Bond was graduated from Ohio State University College of Medicine in 1957.

The Midwest Interprofessional Conference will be held at Iowa State University, Ames, Iowa, on September 17 and 18. This conference was formed several years ago to aid members of various professions to keep abreast of research on diseases common in animals and man. Papers will be presented in the areas of the leukemia complex, toxoplasmosis, salmonellosis, trichinosis and aging and vascular change.

The Military Medical Supply Agency and the Veterans' Administration have sent millions of the taxpayers' dollars overseas to purchase cheap, pirated versions of powerful drugs discovered by U.S. companies and presumably protected by U.S. patents. This practice was deservedly denounced by American labor when the Oil, Chemical, Atomic Workers International Union passed a resolution strongly condemning it. When the government goes shopping, the taxpayer has a right to expect that it will spend his money wisely, for a good purpose and for the general welfare of the country. —U.S. Senator Hugh Scott in 87th Congress.

"We trust the Congress has gumption enough not to approve some of the ideas of the coonskin-crowned Senator about drug patents. To do so would only sound the death knell of pharmaceutical research. The Senator's ideas about lack of competition are not factual; he simply doesn't know what he is talking about . . . His plan to make a federal bureau the judge of efficacy is nonsensical. The clinician at the bedside is the one to determine efficacy. The politically-climbing Senator would lodge too much autocratic power in a Washington bureau which might become dictatorial."—Editorial in The West Virginia Medical Journal,

Polio victims received more than $4.3 million in benefits from insurance companies in the first nine months of 1961, the Health Insurance Institute has reported. Polio benefit payments by insurance companies were slightly less than last year, but the incidence of polio was sharply down from 1960. The fact that benefits did not decline as rapidly as the polio incidence illustrates the cost of long-term recuperative and treatment needs involved in the illness, the HHI said.

Seventeen physicians in San Marino, a republic of 17,000 inhabitants, staged a 24-hour strike in December for higher wages. The doctors were asking wage increases of 10 per cent from the San Marino State Social Security System which employs them. Average monthly pay is now 65,000 lire ($104). Residents needing medical attention that day had to go to Italy, whose territory surrounds San Marino.

"In the past 15 years there has been a striking growth in clinical research as a two-way bridge between the laboratory and clinical practice. Coupled with this is the achievement of the pharmaceutical industry in the manufacture, quality control and marketing of new products. In consequence, the lag between scientific discovery and widespread use of new drugs has been shortened."—Luther Terry, M.D., Surgeon General, U.S. Public Health Service, to 1961 National Health

"The ability and willingness of the drug industry to in- vest vast sums in research, in new methods of production and in factories, as well as their proficiency in mass production and rapid distribution, have contributed greatly to medical knowledge and the service that we, the members of the medical profession, are able to give to the public. Their cooperation, along with the aforementioned facts, has produced probably the finest system of medical practice and care in the world."—Irving Rubin, M.D., in Annals of the District of Columbia, October 1961.

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Pages 751-774

Despite all the seeming inefficiencies of free competition, I would rather be deluged with more medicinal preparations than I know how to use than be forced to sit idle at the bedside of a patient doing nothing because there are not enough drugs to save lives or, at the very least, to bring comfort to my patients. I would rather be accused of trying too hard to market my useful products than to default on marketing and, thus, to lose sales and thereby increase costs. I would rather be stacked up over an airfield for two hours in a 1961 jet than to have the sky all to myself in something like the Wright Brothers' original flying machine. I prefer to suffer the pangs of perplexity in having countless alternatives in the purchase of a new car than to have no choice at all.—Theodore G. Klumpp, M.D., President, Winthrop Laboratories, in *New York Medicine*.

Accidents, poisonings and violence made up the fourth highest diagnosis group during the 12 months ending Sept. 30, 1961, according to the quarterly report of the National Disease and Therapeutic Index, compiled from reports of 1,500 physicians on all private patient contacts during a 48-hour period once each quarter. Fractures, sprains, lacerations and other injuries accounted for 924 of every 10,000 patient contacts with private doctors. **J. Murray Kinsman, M.D.,** dean of the University of Louisville School of Medicine, is a member of the advisory committee of physicians and educators to the Index.

Enrollment in nationwide Blue Shield Plans passed the 48,400,000 mark at the end of September, 1961, according to John W. Castellucci, executive vice president of the National Association of Blue Shield Plans.

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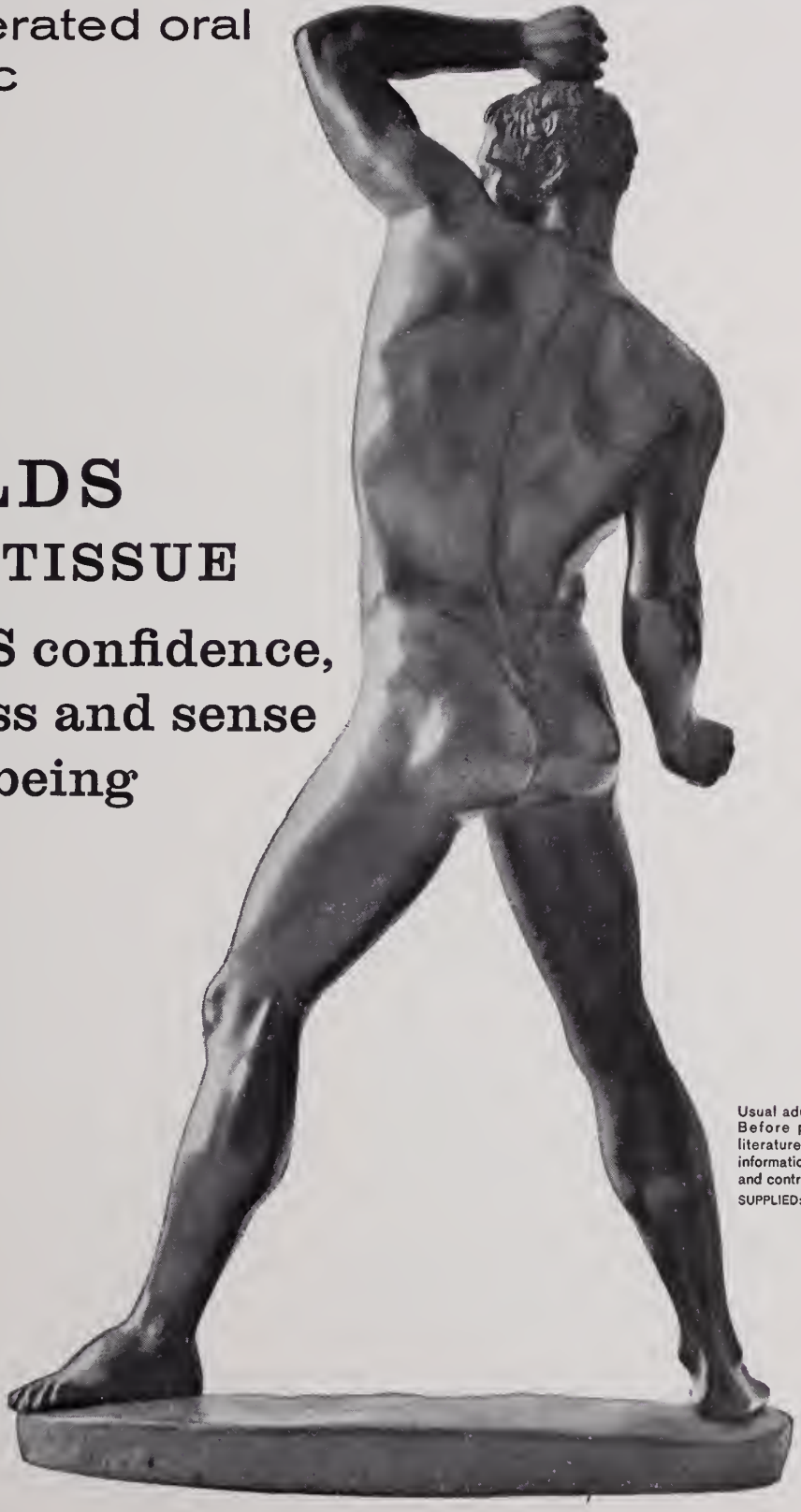
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IN THE BOOKS

Huber, A., Eye Symptoms in Brain Tumors, St. Louis, C. V. Mosby Co., 1961, translated from German to English by Stefan Van Wien. $16.00

This volume, in 250 pages of text simply divided into five basic chapters, was written by a younger member of the remarkable group of Swiss opthalmologists who have contributed so richly to the world's literature.

Dr. Huber's material has been developed from analysis of 1600 cases seen by him as ophthalmologist to the University of Zurich Neurosurgical Clinic. More than 50% of these patients presented eye symptoms, and this volume brings unique focus to this crossroad of ophthalmology and cerebral oncology.

Originally published in German in 1956, it was included in the distinguished series, *Innere Medizin und ihre Grenzgebiete* of Rossier and Spuhler. The production of an English translation after weathering 5 years on the Continent immediately evidences intrinsic value.

The task of translation is technically well consummated, but at the usual loss of charm and character in the writing. The volume is not engaging for protracted reading or as a quick reference to specific problems, but rather serves as an intensive study medium or review source in its announced area.

Forty-five pages devoted to papilledema alone, reflect the detail with which each item is followed. The book is written for the complete ophthalmologist, the neuro-ophthalmologist, or the special student in this field. No respectable general medical, ophthalmic or neurologic library should be without this volume.

Arthur H. Keeney, M.D.

W. B. SAUNDERS COMPANY features the following recent books in their full page advertisement appearing elsewhere in this issue:

KLINE and LEHMANN—HANDBOOK OF PSYCHIATRIC TREATMENT IN MEDICAL PRACTICE

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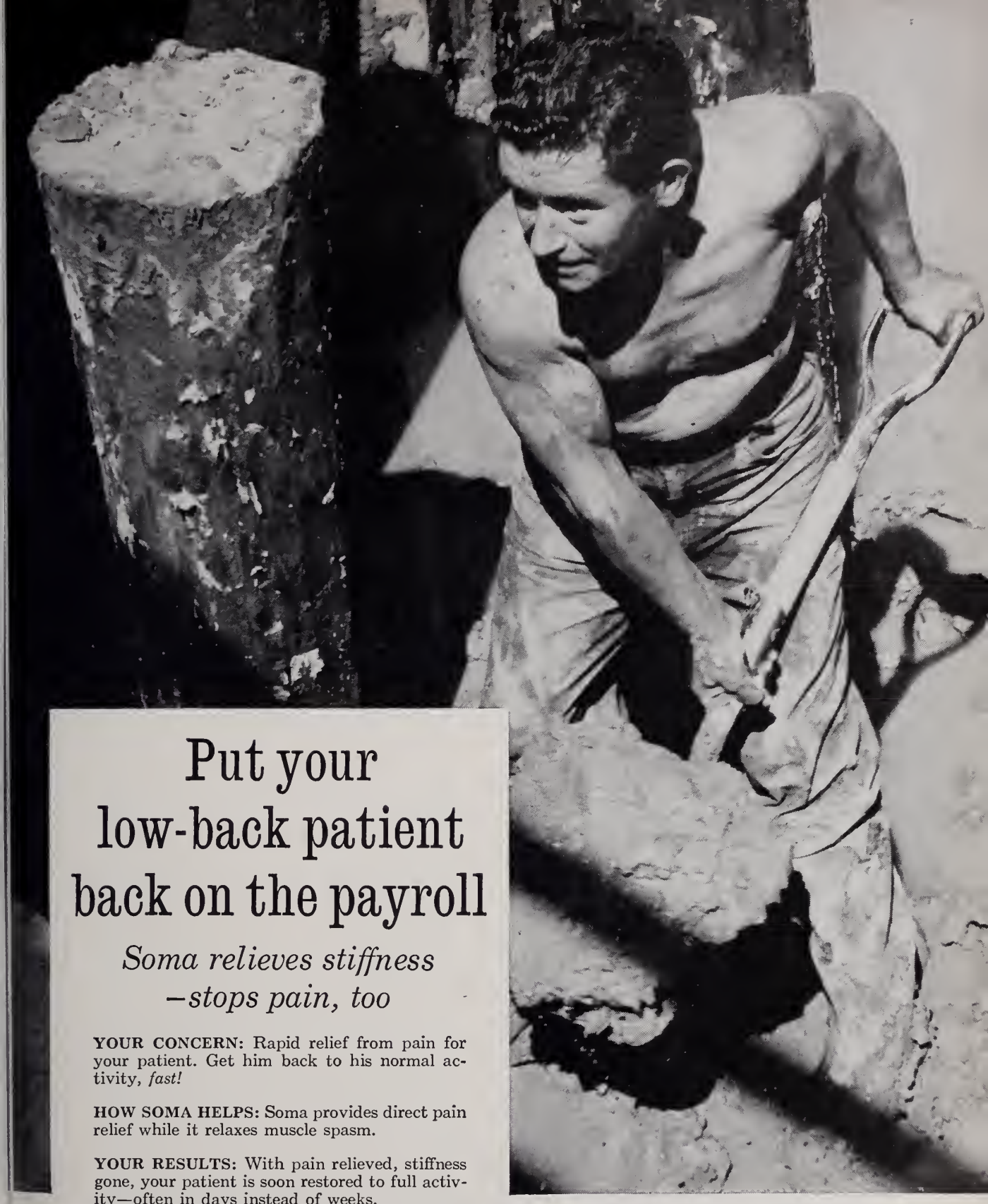
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A. The indemnity allowance will be that for the procedure which has the highest allowance plus one-half the allowance for each smaller procedure, subject to the maximums specified in the certificate carried by the member. (Incidental appendectomies are excluded.)

Q. What do "I.C.", "L-1", "L-2" in the Participating Physicians' Manual mean?

A. I.C. means Individual Consideration. L-1 means that Blue Shield will make only one indemnity allowance for that listed service in one contract year. L-2 means two allowances in one contract year.

Q. If I do not feel that the allowance made for an unusual service is correct, what procedure should I use for reconsideration?

A. A report for unusual services is routinely referred to the Medical Consultant to Blue Shield for consideration. If you feel that still further consideration should be given the case, a request should be made for review by the Blue Shield Medical Advisory Committee, with detailed information to assist in further review.

Q. If my charge for a service is $6.00, but the Blue Shield allowance is $10.00, who gets the extra $4.00?

A. Blue Shield allowances are up to specified indemnities—the Subscribers Certificate states: ". . . in no event shall the payment exceed the physician's charge for the service."

Q. Can a subscriber carry two Blue Shield contracts?

A. The Subscriber Certificate states: "No person shall be covered either directly or indirectly by more than one Blue Shield contract."

Q. What procedure should I use in requesting a visit from a Blue Shield representative?

A. There is a space provided on the Blue Shield Service Report to request a call from a representative. Place a check mark in the appropriate space or write, or phone the Hospitals-Physicians Service Department at 3101 Bardstown Road, Louisville 5, Kentucky.

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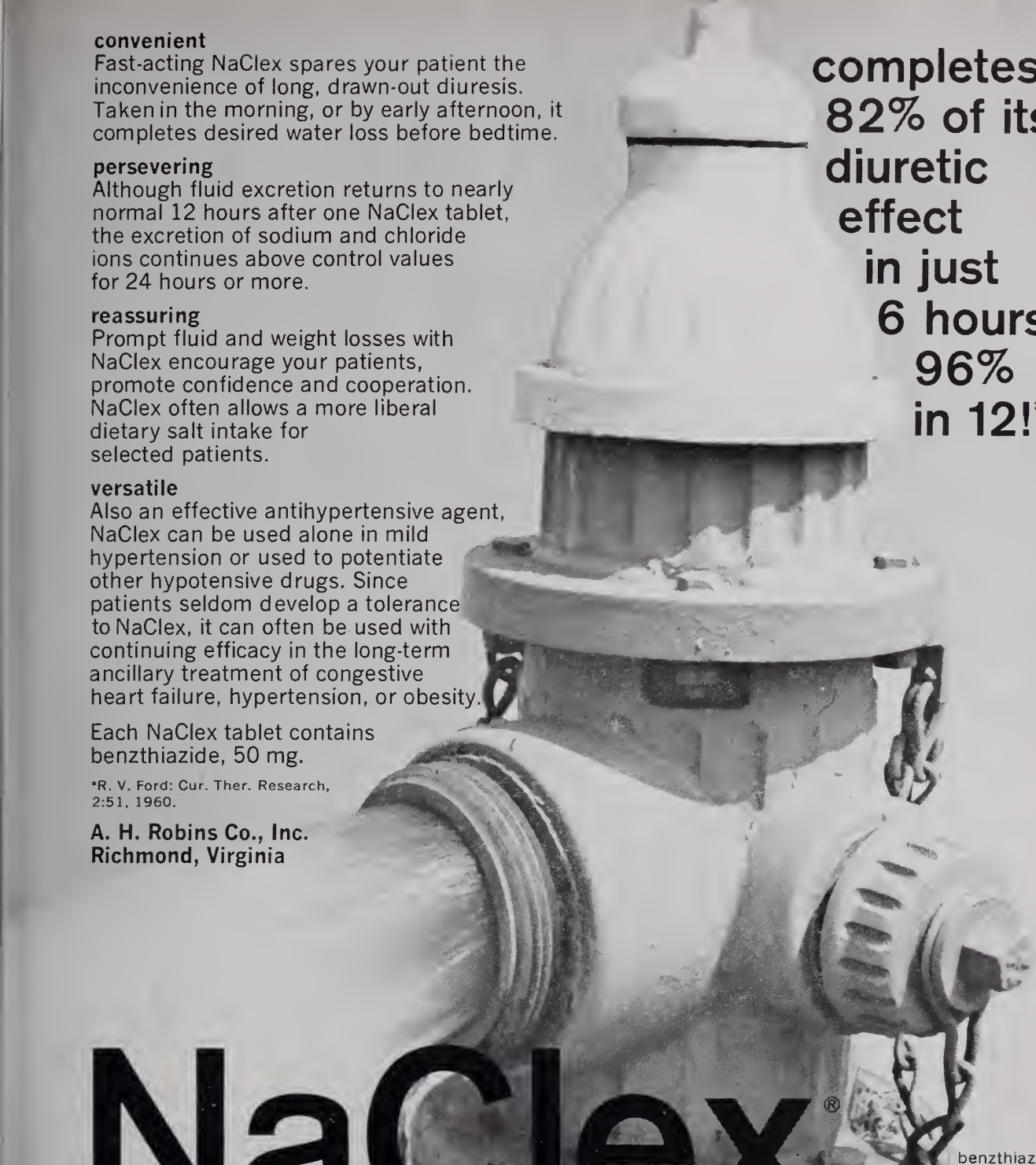
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*R. V. Ford: Cur. Ther. Research, 2:51, 1960.

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CASE #101—The patient was a 36-year-old married, white, gravida 11 para 9 ab 1, who had not presented herself for prenatal care even though her last three pregnancies had been complicated by eclampsia. Her pregnancies prior to these were normal in every respect, and had eventuated in the delivery of living children. Her last pregnancy 1½ years before admission had terminated in abortion at 4½ months, and she had been repeatedly advised against further pregnancy. She had refused sterilization.

On August 13, 1960, the patient was hospitalized complaining of basilar headache, dizziness and drowsiness; these complaints had been noted for the past three weeks, and had gradually increased in intensity, The day before admission, she began having lower abdominal pain simulating contractions.

On physical examination, she was a thin, emaciated, pale adult who appeared acutely ill. The blood pressure was 170/30. The uterus was enlarged to a size compatible with a 7 months' gestation. There were varicosities of both legs, and moderate dependent edema. The arms and legs showed muscular twitching movements. The working diagnoses were possible premature labor, preeclampsia, and chronic nephritis. The patient was given Diuril, ammonium chloride and hypertonic glucose, but the blood pressure remained elevated.

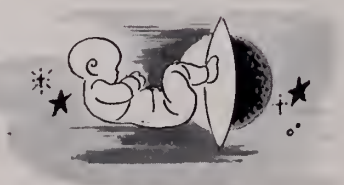
Labor began spontaneously and she delivered a 2 lb. 2 oz. living girl. Trilene analgesia was given. Post-partum, the blood pressure remained at 190/126 and the headache and muscular twitching worsened. Ultimately, she demonstrated mild convulsive seizures, and lapsed into a coma. The urinary output was reduced despite continued administration of diuretics. Azotemia developed progressively, and by the eleventh day, the day of her death, the non-protein nitrogen had risen to 177.5 milligrams per cent.

Permission for autopsy was refused.

The final diagnoses were recorded as (1) Premature delivery; (2) Eclampsia; (3) Nephritis with terminal uremia.

Committee Comments

The committee considered this case to be one of direct obstetrical death with a preventable factor, the lack of prenatal care, for which the patient was responsible. The protocol does not give enough clinical details to make possible a critical evaluation of the correctness of either diagnosis or management of this case.





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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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PUBLIC HEALTH PAGE

Reporting Of Food-Borne Disease Outbreaks

RUSSELL E. TEAGUE, M.D., M.P.H. *Comissioner of Health Commonwealth of Kentucky*

IN 1960 there were 187 food-borne outbreaks involving 7,482 people reported to the United States Public Health Service. One state, California, reported 91 outbreaks or nearly one-half the total number. Only six other states reported more than five outbreaks. Twenty-two states with a combined population of 45,000,000 persons reported no outbreaks of food-borne disease.

The actual extent of preventable food-borne illness is unknown because of inadequate reporting but authorities concerned with the problem indicate that the incidence is high. One investigator estimates the occurrence of 60,000 to 90,000 cases of food-borne illness per year while another noted authority believes there may be several hundred thousand.

Detection of cases and prompt notification of the health department many times constitutes a difficult problem because:

(1) Affected individuals with short term gastroenteritis may not seek medical attention.
(2) Frequently, medical examination of patients does not yield enough information to establish the causative agent or to indicate its possible source; therefore, the physician may have insufficient data to warrant notification of the health department.
(3) Unless the onset of symptoms occurs under circumstances of time, location, communications, etc., which permits association of multiple cases with a common source, food may not be suspected.
(4) When food is implicated in an outbreak involving its manufacture, sale, preparation, or serving, some people may desire to supress the information to avoid unfavorable publicity or legal actions.
(5) It may be that the physician dealing with the outbreak is not aware that the health department, local or State, has services for investigation and control of such outbreaks.

The State Department of Health maintains a team to investigate outbreaks of disease including food poisoning. This team includes epidemiologists, sanitarians, nurses, and other specialists when needed. The physician and people of the Commonwealth are also fortunate in having modern public health laboratories for bacteriological and chemical examination of food and water. The laboratory staff is among the best trained in the United States and has had wide experience in the examination of food involved in food-borne disease outbreaks.

Experience has taught that investigation of one such episode frequently unmasks others and exposes conditions likely to perpetuate recurrences. With better reporting by physicians and follow-up epidemiological investigations including diagnostic laboratory analysis, much valuable information would be obtained which would be useful in formulating a realistic approach to this problem. The physician will derive benefit for his patients and the community in which he serves as a guardian of health. He is the key person in the eradication of food borne disease outbreaks.

**This article was prepared by: Harry A. Marsh, Jr., Assistant Director, Division of Public Health Sanitation, Kentucky State Department of Health.*



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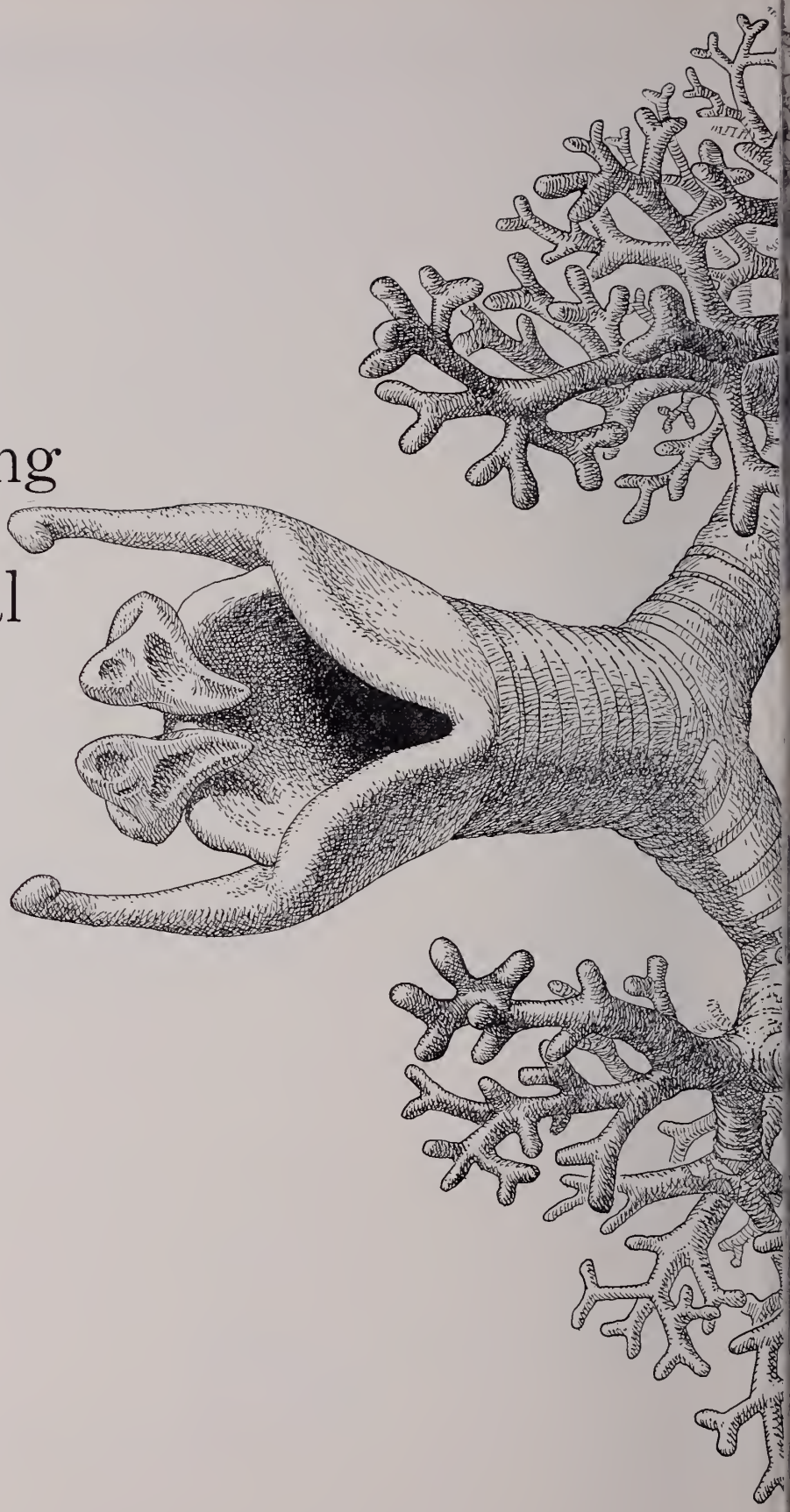
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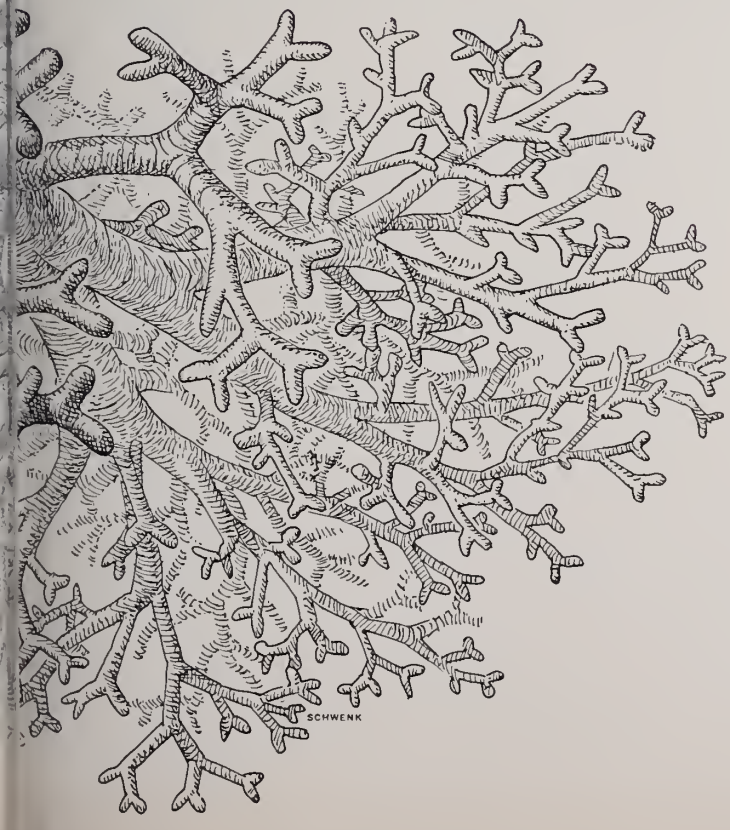




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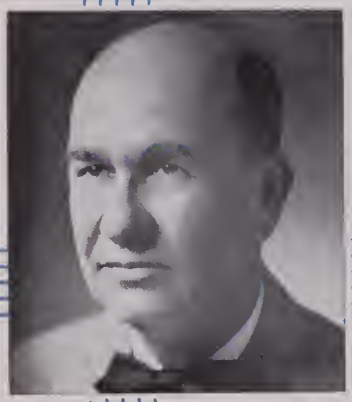


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KSMA's Accomplishments in 1961-1962

Within a few weeks, the curtain will ring down on another Associational year of activities of KSMA. There have been several accomplishments worthy of note.

1) The Key Man System of political activity was demonstrated to be effective during the 1962 Kentucky General Assembly, with able leadership at both Committee and Field Service levels.

2) There was a definite and gratifying improvement in physician participation in political affairs (The Science of Government), at a national level.

3) KSMA constructed and occupied its first permanent home, formally dedicated in a colorful ceremony May 20, 1962. Its Headquarters' activities will be facilitated by additional space and a more efficient unit arrangement.

These and other progressive steps made during the year would not have been possible without the earnest and dedicated effort on the part of the Trustees, Council, Committee members, County Society officers, individual physicians, and the Headquarters' personnel.

D. S. Simpson

For Bronchial Asthma

EACH TABLET CONTAINS

Aminophylline	2 grains
Ephedrine HCl	¼ grain
Potassium Iodide	3 grains
Phenobarbital	⅓ grain

mùdrane®



A combination of the most widely recognized drugs for the treatment of asthma . . . . compounded for maximum absorption and balanced action, and buffered for tolerance

Dispensed in bottles of 100 and 1,000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

If you have patients on a cholesterol depressant diet, this will be welcome news:

General Mills is now making available, through grocery stores, a Safflower Oil which is totally acceptable in the diet, and which is priced reasonably.

SAFF·O·LIFE
Safflower Oil



As you know, Safflower Oil is higher in poly-unsaturates and lower in saturated fats than any other type of readily available vegetable oil.

When an increased poly-unsaturated fatty acid intake is desirable, you can recommend Saff-o-life Safflower Oil. You can do so with the assurance that the patient will find it completely appetizing—clear, light and fresh-smelling—and priced at a level which poses no problem.

Ratio of Linoleates* to Saturates
*(Poly-Unsaturates)

SAFFLOWER OIL • 9.0 to 1.0
CORN OIL • 5.3 to 1.0
SOYBEAN OIL • 3.5 to 1.0
COTTONSEED OIL • 2.0 to 1.0
PEANUT OIL • 1.6 to 1.0

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to General Mills, Inc. Address your inquiries to Professional Services Director, General Mills, Inc. Dept. 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.



Sustained tranquilization without autonomic side reactions

- SAFE, CONTINUOUS RELIEF of anxiety and tension for 12 hours with just one capsule—without causing autonomic side reactions and without impairing mental acuity, motor control or normal behavior.
- ECONOMICAL for the patient—daily cost is only a dime or so more than for barbiturates.

Meprospan®-400

400 mg. meprobamate (Miltown®) sustained-release capsules

Usual dosage: One capsule at breakfast lasts all day; one capsule with evening meal lasts all night.

Available: *Meprospan-400,* each blue-topped capsule contains 400 mg. Miltown (meprobamate).
Meprospan-200, each yellow-topped capsule contains 200 mg. Miltown (meprobamate). Both potencies in bottles of 30.

WALLACE LABORATORIES / *Cranbury, N. J.*

CME-6630



A Splendid Partnership

JUST a little more than three decades ago, Blue Cross came into being. At that time, the concept of prepayment for hospital expenses was a new and daring idea, but one which was soon found to be practical and workable.

The success of this type of non-profit plan, sponsored by the hospitals, was so overwhelming that many medical societies soon began to participate in the development of plans for the prepayment of physicians' fees. Thus was started the Blue Shield movement under which almost one out of every four Americans is protected against the costs of illness today.

Basic Objective

Since the basic objective of both Blue Cross and Blue Shield is to enable people to obtain for themselves adequate health care through the voluntary non-profit prepayment mechanism, it would seem logical that there should always be harmony and cooperation between these plans.

Such is usually true; but it must be acknowledged that in a few areas in our country, Blue Cross and Blue Shield plans have become unfriendly rivals rather than cooperative partners.

We in Kentucky—hospitals, physicians and the public—have been most fortunate in this regard. When the Kentucky State Medical Association decided to develop and sponsor a Blue Shield plan, Kentucky Blue Cross, which was already a thriving and well run organization, was asked to administer the new plan.

The executive director of the Blue Cross Hospital Plan and his staff brought to this task a group of experienced and well-trained personnel who were devoted to the voluntary non-profit prepayment principle. From the first these men have demonstrated the same loyalty and zeal toward the Blue Shield Plan which they had showed toward Blue Cross.

Plans Have Prospered

Through the efforts of this joint staff, both plans have continued to grow and to prosper. It is no accident that the Kentucky Blue Shield Plan for the past several years has ranked near the top nationally both in rate of growth and in the low percentage of the premium dollar spent on administrative costs.

Each plan, of course, has its own governing board which sets policies and directs the activities of the staff. There has never been any major disagreement in policy between the Blue Shield board of directors and the Blue Cross board of trustees. The affairs of both organizations have been handled by the administrative staff with complete lack of partiality toward either organization as opposed to the other.

Because of this fine relationship between the two groups there has been and will continue to be a constant improvement in the protection offered to our subscribers.

What better argument can we give against compulsory governmental health care than to point to this constant improvement in the voluntary prepayment mechanism and to prove that our people are happy with this protection.

W. Vinson Pierce, M.D.



GLYNAPHYLLIN

A bronchial relaxant preparation designed for the treatment and prophylactic management of bronchial asthma, asthmatic bronchitis and other bronchial diseases including chronic pulmonary emphysema in which spasm of the bronchial smooth muscle may play a role.

COMPOSITION:
Each Tablet contains:

Aminophyllin	3 grains
Phenobarbital	1/4 grain
Ephedrine Sulfate	3/8 grain

ADMINISTRATION AND DOSAGE:
For the prophylactic management of the asthmatic, 1 tablet every 6 or 8 hours may suffice, although the physician may employ larger doses for this purpose. In acute attacks of bronchial asthma, GLYNAPHYLLIN may be considered an adjunct to other forms of treatment and dosage must be adjusted to the individual patient.

CONTRAINDICATIONS:
GLYNAPHYLLIN should not be administered to patients who suffer from associated gastro-intestinal disease which may be aggravated by nausea and vomiting. The preparation is contraindicated also in hypertension and other cardiovascular diseases in which ephedrine is undesirable. Because of its phenobarbital content, GLYNAPHYLLIN can be habit forming and is contraindicated in patients in whom drowsiness is a significant disadvantage.

HOW SUPPLIED:
In bottles of 100, 500 and 1,000 tablets.

GLYNAPHYLLIN
is another "Established Need" product

(FTP) First Texas *Pharmaceuticals, Inc.*
DALLAS • SINCE 1901 • ATLANTA

WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—Reports of possible serious side effects of three drugs led to studies and investigations by the drug industry, the American Medical Association and the Federal government.

Most attention was given to thalidomide, a non-barbiturate which produces sleep without a "hang-over." Births of malformed babies, mostly in foreign countries, by mothers who took the drug during pregnancy were widely reported.

The Pharmaceutical Manufacturers Association established a special drug safety group to broaden scientific knowledge regarding predictability of the effect of potent drugs on humans.

The AMA started a special study of thalidomide. A Senate subcommittee opened an investigation. One of the first official acts of the new secretary of Health, Education and Welfare, Anthony J. Celebrezze, was to order a tightening of FDA controls over drug testing.

Thalidomide in West Germany

Thalidomide was first marketed in West Germany about five years ago. It was consumed widely in West Germany, Great Britain, Australia, Portugal and Canada. One of its uses was as an antidote for the morning sickness of early pregnancy. No significant side effects, either proved or suspected, were reported until 1961.

The parent company of Wm. S. Merrell Co. of Cincinnati, Ohio, obtained in 1959 the North American marketing rights for the drug. Merrell conducted laboratory and mass clinical tests, put the drug on the market in Canada and in September, 1961, applied for FDA approval for U.S. sales.

Dr. Frances O. Kelsey, a newly employed medical officer at FDA, moved cautiously on the application and withheld approval. In February, 1961, she read a letter in the British Medical Journal suggesting that thalidomide might be causing peripheral neuritis.

For withholding FDA approval of the drug, Dr. Kelsey was awarded the Distinguished Federal Civilian Service Medal by President Kennedy. The President at the same time renewed his request to Congress that it approves the Administration's drug legislation.

First reports linking thalidomide with birth malformations reached Merrell from the German drug manufacturer in November, 1961, after a German scientist reported such indications at a medical meeting. Merrell promptly sent a warning to Canadian doctors and the approximately 1200 American doctors conducting clinical tests with it. It was requested that the drug not be given to women of child-bearing age. Merrell so advised the FDA at the time also. In early March, 1962, Merrell withdrew the drug from the Canadian market and experimental use in this country, and dropped its FDA application.

The PMA announced establishment and financing of a Commission on Drug Safety to, among other activities, "investigate an unpredictable problem which is assumed to be connected with use of the European drug (thalidomide)." Lowell T. Coggeshall, M.D., a leading U. S. scientist and vice president of the University of Chicago, was named chairman of the commission. He formerly was president of the American Association of Medical Colleges and of the American Cancer Society.

"The basic purpose of our commission is to study the broad and complex problems of making available to the public, with adequate safeguards for both the doctor and the patient, the therapeutic advances which will result from the enormous programs and rapid pace of medical research," Doctor Coggeshall said.

"However promising new agents may be in the laboratory, no amount of laboratory experimentation and testing can provide complete assurance of effectiveness or safety when a new drug is administered to a human being. We must attempt to reduce danger to the lowest possible degree without discouraging the imaginative research from which flows mankind's increasing release from disease."

Action of AMA Council on Drugs

The AMA Council on Drugs began a comprehensive analysis of the effect of thalidomide on unborn infants.

In a statement, the council said:

"The AMA has been concerned about the reports of distinctive congenital malformations occuring in the offspring of patients receiving thalidomide in early pregnancy. . . .

"It has been under clinical evaluation here since 1956. There have been no published reports in scientific journals of such malformations developing in connection with these trials in the United States.

"On the evidence which has been presented, it would appear that the increased incidence of extromelia in Germany, Great Britain and Australia may be related to the use of thalidomide during the early weeks of pregnancy.

"A careful analysis of the whole problem is needed. This has not yet been done and the Council on Drugs proposes to undertake a comprehensive analysis. Through such studies, it is hoped that further knowledge will be gained on the problem of congenital malformations and appropriate measures will

(Continued on Page 904)





1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New
GRIP-TIGHT CAP
for Children's
Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.



Answers To Questions About Your

BLUE SHIELD

Q. What is the proper manner in which to describe the surgical treatment of a laceration?

A. Please report the location, length, and depth of the laceration and the approximate number of sutures.

Q. Does the "Federal employee" who is a member of Blue Shield have a "Service Contract" similar to Medicare?

A. No, the Federal employee who is a Blue Shield member in Kentucky does not have a service contract and this plan is in no way related to the Medicare Program. The Federal employee medical and surgical plan in Kentucky is quite similar to Preferred Blue Shield. Both are indemnity contracts.

Medicare was established by the 84th Congress under the provisions of Public Law 569, to furnish certain benefits for eligible wives, children, and dependent husbands of active duty personnel of the Uniformed Services. The Kentucky State Medical Association is the contracting agent with the government for the Medicare program in Kentucky. Blue Shield serves as the fiscal agent at the request of the Kentucky State Medical Association.

Q. If a Blue Shield member who is single, marries and reclassifies to a family contract within 60 days after the marriage date as required, how soon would they be eligible for maternity benefits?

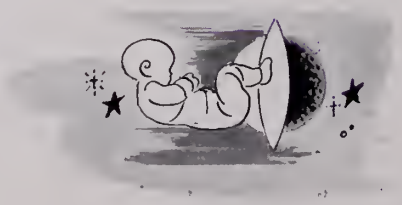
A. It is the policy of Blue Shield to honor a maternity claim, under the above stated conditions, seven (7) months following the effective date of the family membership.

Q. When a Blue Shield member moves to another State, what is the proper procedure for transferring their membership to the other Plan area?

A. If the Blue Shield member is paying his dues on a direct basis, he should write or call the Blue Shield home office Transfer Department and provide them with the date of the requested transfer and future mailing address. If the Blue Shield member is moving into another Plan area but will be covered through a group contract, he should initiate his transfer with the Blue Shield Group Leader of business by whom he will be employed.

Q. To whom should I direct correspondence when requesting information concerning a Blue Shield claim?

A. Mr. Robert McCracken, Blue Shield Claims Manager, 3101 Bardstown Road, Louisville 5, Kentucky.



Relieves Anxiety and Anxious Depression



The outstanding effectiveness and safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past six years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets, bottles of 50. Also as MEPROTABS® — 400 mg. unmarked, coated tablets; and in sustained-release capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

CM 6709

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms, liver damage or agranulocytosis
3. Does not muddle the mind or affect normal behavior



NEW!

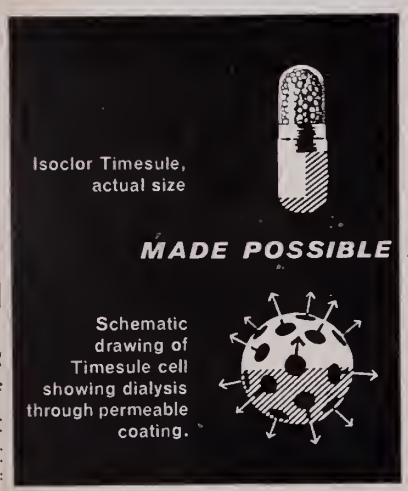
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HAY FEVER DISTRESS

ISOCLOR® TIMESULE®

A NEW COMPREHENSIVE RELIEF

- **Relief usually starts in minutes**—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- **Relief usually lasts up to 12 hours** with a single oral dose
- **Gives both** upper respiratory decongestion and bronchodilatation to relieve chest discomfort
- **With minimal** drowsiness, CNS or pressor stimulation



MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

EACH ISOCLOR TIMESULE CONTAINS:

Chlorpheniramine maleate ..... 10 mg.
d-Isoephedrine HCL ..... 65 mg.
In a special form providing prolonged therapeutic effect.

DOSE: Adults: One Timesule every 12 hours, or as directed.

WARNING: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

ARNAR-STONE LABORATORIES, INC.,
Mount Prospect, Illinois.



"opened nose clear to the ears"[1]



This was how one patient described the nasal decongestant action of Dimetapp Extentabs. How would *your* patients describe it? From the first tablet, Dimetapp Extentabs provide prompt and prolonged relief from the stuffiness, drip and congestion of upper respiratory conditions, with exceptional freedom from side effects. The reason is in the formula: the potent antihistamine with side effects as few as placebo,[2] DIMETANE® (brompheniramine maleate, 12 mg.) and two outstanding decongestants, phenylephrine HCl (15 mg.) and phenylpropanolamine HCl (15 mg.)...all in dependable, long-acting Extentab form.

NEW DIMETAPP ELIXIR (one-third the Dimetapp Extentabs' formula in each 5 cc.), for conventional t.i.d. or q.i.d. dosage in a palatable, grape-flavored vehicle.

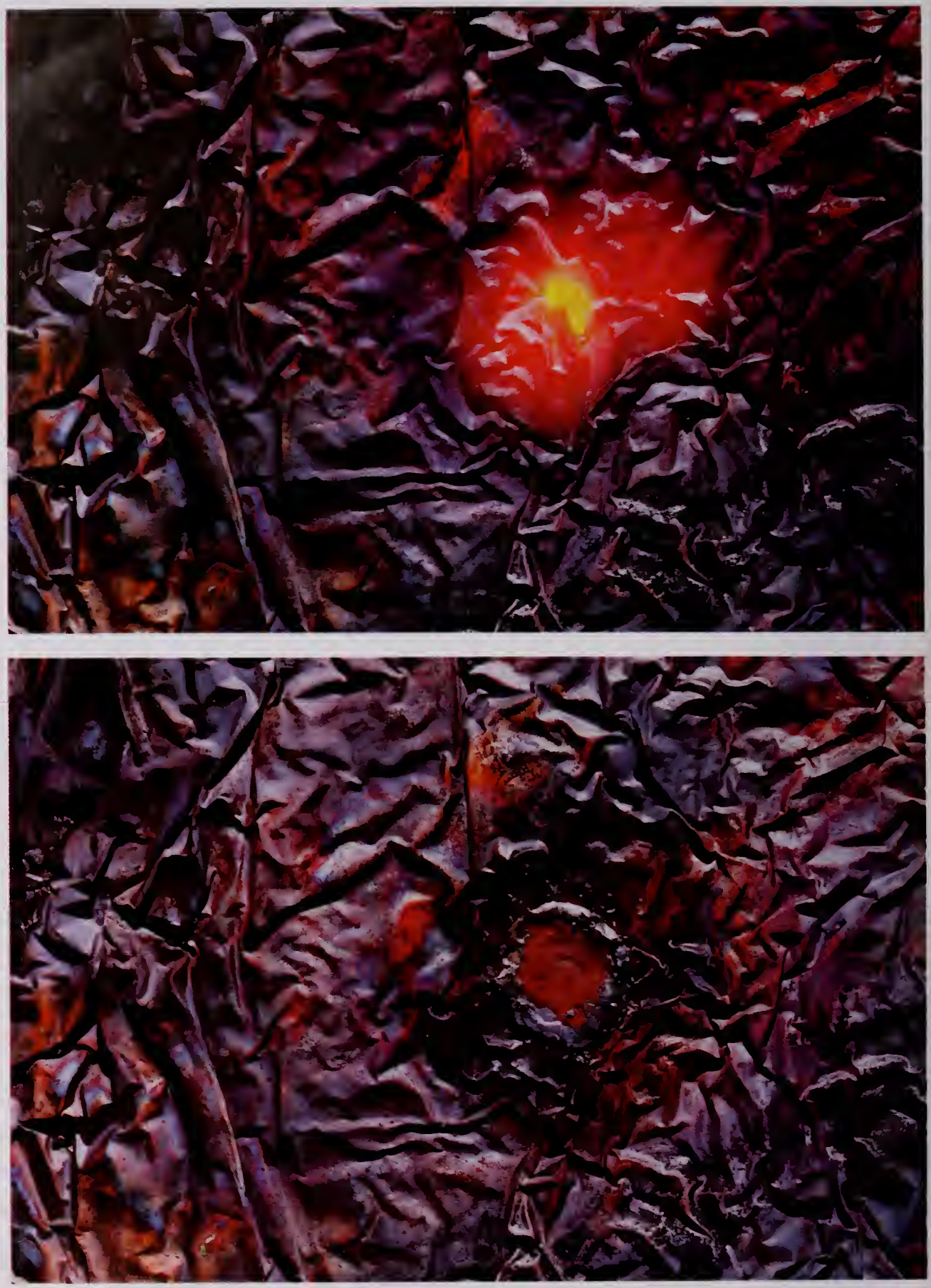
References: 1. Clinical report on file, Medical Department, A. H. Robins Co., Inc. 2. Schiller, I. W., & Lowell, F. C.: New England J. Med. *261*:478, 1959.

for nasal decongestion **Dimetapp® Extentabs®**

in sinusitis, colds, u.r.i., up to 10-12 hours' clear breathing on one tablet

PHARMACEUTICALS · RESEARCH

A. H. ROBINS CO., INC., RICHMOND 20, VA.



The illustration: To dramatize the pain and trauma and healing of the peptic ulcer, our photographer burned a "lesion" into crumpled metal with a blowtorch and photographed it, then repaired the damage and rephotographed the result — the "healed" ulcer.

ulcer under repair

"What results can I expect in my ulcer patients?" Shown below is a tabulation of 795 ulcer patients, reported by 69 investigating physicians, in which glycopyrrolate was the anticholinergic employed. They represent a cross section of ulcer patients of all ages, both ambulatory and hospitalized, under various regimens, from all sections of the country.

Note the pattern of results. Robinul showed an "excellent" or "good" response in over 83% of patients, and Robinul-PH provided similar results in 81%.

As for side effects, these often troublesome extensions of anticholinergic action such as dry mouth, blurred vision, etc., were evaluated as "moderate-to-severe" in only 6.7% of a total of 1705 patients in preliminary investigative studies, 795 of whom are the ulcer cases tabulated here.

We invite you to try Robinul in your own practice. We believe you will find it one of the most effective agents you have ever used for the management of the ulcer patient.

Robinul® (formerly Robanul)
Each tablet contains glycopyrrolate, 1.0 mg.

Robinul®-PH (formerly Robanul-PH)
Each tablet contains glycopyrrolate, 1.0 mg.; and phenobarbital (¼ gr.), 16.2 mg.

Robinul® at work

Brand of glycopyrrolate, Robins

results with Robinul and Robinul-PH in 795 ulcer patients, from 69 clinical investigators*

DIAGNOSIS	ROBINUL					ROBINUL-PH				
	*No. Patients	Excellent	Good	Fair	Poor	*No. Patients	Excellent	Good	Fair	Poor
Marginal Ulcer	11	3	3	3	2	1	0	1	0	0
Pyloric Channel Ulcer	6	3	1	0	2	2	1	1	0	0
Pyloric Ulcer	4	2	1	1	0	1	1	0	0	0
Gastric Ulcer, bleeding	3	1	2	0	0					
Gastric Ulcer	48	31	11	1	5	12	5	7	0	0
Gastric Ulcer, penetrated	1	0	1	0	0	1	1	0	0	0
Gastric Ulcers, multiple	1	1	0	0	0					
Duodenal Ulcer	494	220	195	48	31	99	41	38	13	7
Duodenal Ulcer, bleeding	38	19	15	3	1	2	1	0	1	0
Duodenal Ulcer, obstruction	13	4	3	1	5					
Duodenal Ulcer, perforated	5	2	1	0	2	6	0	3	1	2
Gastric and Duodenal Ulcer	4	2	2	0	0					
Peptic Ulcer, unspecified	25	19	4	0	2	18	8	7	2	1
TOTALS	653	307	239	57	50	142	58	57	17	10
		83.6%					81.0%			

*Clinical reports on file, A. H. Robins Company, Inc.

A. H. Robins Co., Inc.
Richmond 20, Virginia

Stelazine® will stop anxiety—but not your patient!
brand of trifluoperazine

To be truly useful in your office patients, an ataractic agent must not only relieve anxiety; it must also leave these patients sufficiently alert to engage in their normal activities.

'Stelazine' is such an agent. Its ability to relieve anxiety without producing appreciable sedation has been established in thousands of patients and documented by many published reports. Typical is the finding of Kolodny,[1] who concluded that the primary advantage of 'Stelazine' over many other tranquilizers seems to be "its ability to relieve symptoms of anxiety without undue interference with alertness."

When you wish to relieve anxiety, yet encourage the patient to engage in his normal activities, consider 'Stelazine'.

1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

For prescribing information, please see *PDR* or available literature.

Smith Kline & French Laboratories, Philadelphia
leaders in psychopharmaceutical research

SK&F





When treatment for

IMPOTENCE

is indicated

ANDROID™ tablets

ANDROGEN-THYROID-COMBINATION

in two convenient dosage forms

ANDROID	ANDROID-H.P. (High Potency)
Each yellow tablet contains:	Each orange tablet contains:
Methyl Testosterone ....2.5 mg.	Methyl Testosterone .....5 mg.
Thyroid Ext. (1/6 gr.) ....10 mg.	Thyroid Ext. (1/2 gr.) ....30 mg.
Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.
Thiamine HCl ..... .10 mg.	Thiamine HCl .....10 mg.

INDICATIONS: Im otence in male.

AVERAGE DOSE: One tablet three times daily.

AVAILABLE: Bottles of 100 and 500 at your pharmacy.

CAUTION: Not to be used when testosterone is contra-indicated. Federal law prohibits dispensing without prescription.

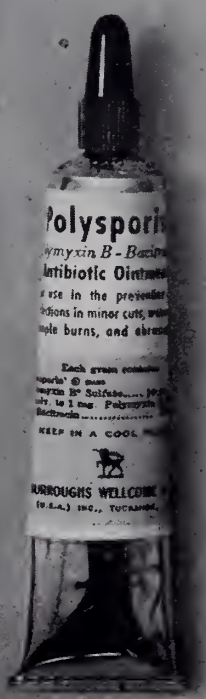
1. *Methyl-Testerone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice*, Vol. 25, No. 2, February 1962 pp 6-8

2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin Endocrinology and Metabolism*, August 1959

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in treating topical infections no need to sensitize the patient

USE 'POLYSPORIN'® brand

Polymyxin B–Bacitracin Antibiotic Ointment

broad-spectrum antibiotic therapy with minimum risk of sensitization

Supplied in ½ oz. and 1 oz. tubes

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Serenium

Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

Serenium® is a Squibb trademark.

SQUIBB *Squibb Quality—the Priceless Ingredient*

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Accredited psychiatric hospital for private diagnosis and treatment

Approved by the Joint Commission of Accreditation of Hospitals.

Forty-acre estate to assure privacy in a restful environment.

Equipped to provide all modern and acceptable methods of treatment.

Ample classification facilities with qualified psychiatric nursing.

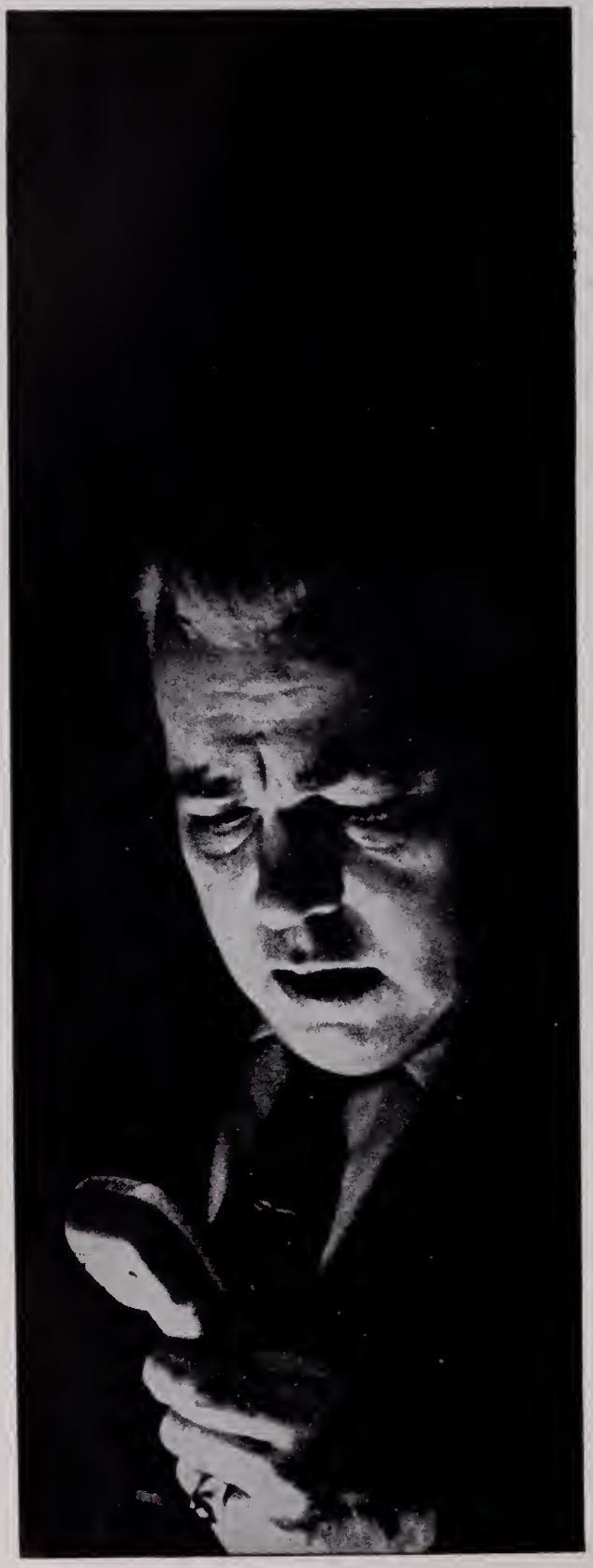
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Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

New ISUPREL® compound ELIXIR

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New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.



one of the most complete Optical Services in Kentucky...since 1897

CONTACT LENS Service
ARTIFICIAL EYE Service
on Ophthalmologists' prescription ONLY

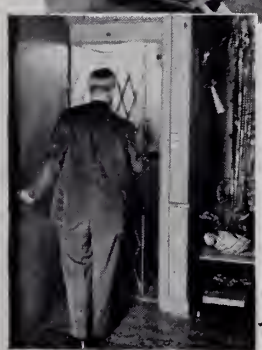
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For You Who Must Advise *"No Stair Climbing"*

Of course, the potient willingly accepts your advice for his own well-being. But, os you hove discovered, he can develop o feeling of being hemmed in by confinement to o single level—o feeling of "apartness" from family life.

Three home lifts—INCLIN-ATOR, INCLINETTE and "Elevette"—carry the patient upstoirs or down without effort on his part. They open the woy to multi-level living and restore him to the center of family life. Eoch con be recommended os safe ond dependable for oll oges.

INCLIN-ATOR — The originol "sit-down" method of climbing stoirs. Runs up stairs on on inconspicous steel channel, folds oganist woll when not in use. Carries two passengers.

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VOL. 60 SEPTEMBER, 1962 NO. 9

Protocol—Transatlantic Clinicopathological Conference on

RENAL DISEASE

KSMA ANNUAL MEETING

Columbia Auditorium **2 p.m., Wednesday, September 19**

The Glasgow, Scotland, Case History

THE PATIENT, a 56-year-old white male, was first seen at Glasgow Royal Infirmary early in 1959 because of a minor head injury. The blood pressure was noted to be 200/96 mm. Hg.; he did not have any hypertensive symptoms.

He was next seen in April 1962 complaining of severe breathlessness and tiredness of three months' duration. No history of significant past illness was elicited. He had been a heavy cigarette smoker (30/day) until a few weeks previously.

Slight Ankle Oedema

Physical examination revealed slight ankle oedema, overfilling of the neck veins, a B.P. of 220/130 mm. Hg., a left ventricular type of apex impulse situated in the sixth left intercostal space one-half inch outwith the midclavicular line, a soft apical systolic murmur and a few basal crepitations. The fundi showed marked arteriolar narrowing and irregularity and bilateral exudates.

A diagnosis of hypertensive cardiac failure was made and he was admitted for investigation and treatment on May 1, 1962.

The Council on Scientific Assembly and Arrangements of the Kentucky State Medical Association urges that the material on the accompanying pages be read in advance of the Annual Meeting, September 18-20. The program is sponsored by Smith, Kline & French Laboratories, Philadelphia, Pa. (See news story about Transatlantic CPC on page 880.)

Investigations

Blood: Hb. 13.3 gm., P. C. V. 38%, W.B.C. 5,300/c.mm.
Film: Normal. E.S.R. (Westergren). 56 mm. in one hour (several readings of this order obtained.)

Urine: Trace of protein. Urine microscopy negative by Addis technique. Culture negative.

Blood urea: 38 mg./100 ml. (See Table I for later readings.)

Endogenous creatinine clearance: 78 ml./-min.

Chest x-ray (Figure 1): Left ventricular enlargement. Passive congestion of lungs. (see next page.)

E.C.G.: Apical and postero—lateral ischaemia.

Intravenous pyelogram (May 8, 1962) (Figure 2): Normal pattern on L. side, but no dye seen on R. side. (see next page.)

Isotopic renogram: Delayed clearance from L. kidney.

Urinary catechol amines: 138 micrograms/-day.

Aortography (Figure 3): L. renal artery stenosis. (see next page.)

Divided renal function studies (four hour collections):

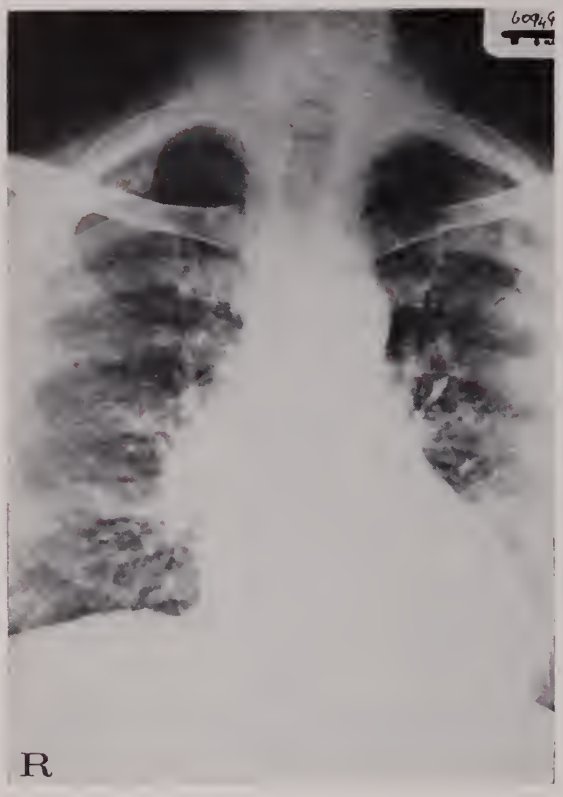


Figure 1

	R. Kidney	L. Kidney
Volume	490 ml.	105 ml.
Sodium	85.1 meq./vol.	13.5 meq./vol.
Urea	0.54 gm./100 ml.	1.06 gm./100 ml.
Creatinine clearance	58 ml./min.	37 ml./min.

Repeat intravenous pyelogram (May 30) (Figure 4): Normal shadows on both sides.

Pulmonary function tests: These showed findings in keeping with a restrictive ventilatory defect with an alveolar capillary block.

Therapy

While the above investigations were being carried out, he was treated with bed rest, digoxin in the usual dosage, an oral diuretic (bendrofluazide), and an attempt was made to lower the blood pressure with methyl dopa.

The oedema was cleared but he remained severely dyspnoeic and the blood pressure was not lowered even with a dosage of 2 gm./day of methyl dopa. The blood urea rose gradually to 56 mg./100 ml. (Table 1) and the creatinine clearance fell to 57 ml./min.



Figure 2



Figure 3

Further Management

At this stage the Glasgow panel will welcome the views of the Kentucky panel on this case of hypertension and, in particular, their comments on the results of the various investigations performed and on the further management they would have considered desirable. Then Arthur Henry Jacobs, F.R.C.S., F.R.F.P.S., the Glasgow chairman, will give an account of what was in fact done and the outcome.

TABLE 1

Date	Blood urea mg./100 ml.
5/3/62	38
5/9/62	36
5/11/62	36
5/15/62	34
5/21/62	33
5/25/62	40
5/29/62	54
6/1/62	45
6/12/62	50
6/26/62	56



Figure 4

The Kentucky Case History

M. R. IS A 15-year-old girl who was first seen in July 1960 complaining of progressive "knock-knee" deformity which had developed over the preceding two years. X-rays revealed ragged, irregular epiphyseal junctions in the wrists, knees and the lateral ends of the clavicles.

Periosteal Changes

There were also widespread periosteal changes with subperiosteal bone reabsorption and cystic changes as well subperiostially. and cystic changes as well as subperiostially. These were most pronounced in the fingers, femora and tibia. In addition, the skull x-ray showed a "fuzzy," granular appearance, involving the entire cranium.

M. R. was one of five daughters in a family without history of bone or kidney disease. One older sister, age 17, however, had a history of anemia of unknown cause of three years' duration. Subsequent studies on this older sister showed that she, too, had a strikingly similar picture to that of M.R. (Autopsy, in both cases, showed the presence of the same disease.)

The past history was noncontributory except that the patient drank a large amount of water and had had nocturia for several years. She had always been "small" for her age. She did not complain of fatigue, dyspnea or bone pain. There was no history of hematuria, albuminuria or edema, and no history to suggest acute glomerulonephritis. She denied fever, chills, flank pain, dysuria and pyuria. There was no urinary frequency.

Physical Examination

Pulse, 120. Blood pressure, 140/80. Height, 4′, 10″. Weight, 105.

The patient was a small, well-nourished, pale girl, looking younger than her stated age. Her face was rather puffy. The skin was dry and had a cafe au lait pigmentation. There was

Blood Chemistry

	BUN	Na	K	Cl	CO_2	Ca	P	Alkaline Phosphatase
9/60	50	130	3.0	94	22	7.0	6.2	35
2/61	57	136	3.9	107	15	10.0	6.0	15.0
12/61	12.0	138	4.0	95	10.0	7.2	7.9	4.0
3/62	228	131	5.1	92	9.5	7.0	13.1	1.7
4/62	260	132	5.0	93	9.3	7.0	129	3.7

a moderate kyphosis with some sagging of the rib cage.

Pronounced genu valgum deformity was present. There was a slight edema of the ankles. The mucous membranes were pale. The eyes, including the fundi, were not remarkable. The thyroid was not enlarged. The lungs were clear. The heart was enlarged to the left on percussion and the sounds were hyperactive. There was a grade II blowing systolic precordial murmur at the apex and the base.

The urine was pale and showed a pH of 7.0, a specific gravity of 1.012 and a faint trace of albumin. The sediment contained 5-10 WBC/hpf, occasional red cells and occasional granular casts. The hemoglobin was 7.5 gm. %, hematocrit was 22. There were 2,000,000 RBC/cu. mm. The reticulocyte count was 2%. WBC was 7,000 with a normal differential.

Blood Chemistries

Blood chemistries were as follows: BUN 75 mg. %, sodium 140 mEq/1, potassium 4.0 mEq/1, calcium 3.5 mEq/1 and the phosphorous 8 mg. %. The alkaline phosphatase was 35 Bodansky units.

Cystoscopy and retrograde pyelograms were done. The bladder was large but showed no trabeculations. The pyelogram revealed a normal pelvic and calyceal outline bilaterally except for minimal distortion of the clayces of the right upper kidney. The ureters were not dilated and the dye passed freely back down the ureters into the bladder. The kidneys appeared somewhat smaller than normal. There was questionable irregularity of the outline of the right kidney. The cortical thickness showed little, if any, reduction as estimated on the retrograde pyelogram.

Following pyelography, the patient developed a urinary infection with severe vomiting and subsequent dehydration. The BUN rose rapidly to a level of 300 mg.% and the CO_2 fell to 6 mEq/1. Hemodialysis and parenteral fluid therapy restored the patient to her previous state. She was followed for the next 20 months until her death. Treatment consisted of high fluid intake; sodium bicarbonate, 1-2 gm. daily, and Vitamin D, 50,000 units daily for the first 12 months.

Clinical Course

The clinical course was that of gradually increasing renal failure with unremitting anemia and progressive symptoms of fatigue, dyspnea and frequent vomiting. Following Vitamin D therapy, the alkaline phosphatase fell to normal levels and there was improvement in the periosteal lesions described above, as well as in the granular appearance of the skull x-ray. A persistent urinary infection proved difficult to eradicate although it was controlled by various antibiotics given intermittently.

An outline of the pertinent laboratory data is shown in the accompanying tables. The steady progression of the disease is apparent. The course was punctuated by three episodes of vomiting, usually precipitated by respiratory infections. Hemodialysis was carried out four months prior to death because of symptoms of severe uremia.

During the last month of life an increasing

	Hbg	RBC m/cumm	Hct	WBC	Retic	S.G.	Alb	Gluc	pH	WBC	RBC	Casts
9/60	7.5	2.23	22	7000	2.6	1.012	trace	——	7.0	5.10	occ	occ gran
2/61	6.0	2.06	20	5200	3.0	1.003	trace	+	6.0	"	"	"
12/61	7.1	2.19	20	5600	2.9	1.006	1+	trace	7.0	"		
3/62	4.5	1.6	16	7300	3.1	1.005	1+	——	6.0	"		

Chromatography showed a slight increase above normal in urinary amino acids.

bleeding tendency became apparent with hemorrhage from the mucous membranes of the nose and mouth. It was characterized by increased prothrombin time, increased bleeding time and normal clotting time.

The patient's final admission followed the appearance of generalized convulsions, vomiting and coma. She was subjected to intermittent peritoneal dialysis. Despite chemical and clinical improvement, the patient suddenly became pale, restless and sweaty. Her blood pressure was not obtainable. She vomited several hundred cc's. of dark material and expired.

The patient's sister followed a similar course except that she showed no bone deformity. She expired two months before the patient. Examination of the blood and urine of three other sisters revealed no abnormalities.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

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All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

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The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville 5, Kentucky.

The October KSMA Journal

will feature

A Symposium on

INFECTIOUS DISEASES

Surgical Management of Symptomatic Arterial Emboli

Benjamin B. Jackson, M.D.

Louisville, Ky.

The surgical management of 25 cases of peripheral arterial emboli is considered. Delay in diagnosis remains the greatest deterrent to successful restoration of blood flow. Embolism detected before six hours usually results in successful restoration of blood flow. Immediate heparinization is indicated if surgery cannot be undertaken promptly.

THE successful management of arterial emboli requires an appreciation of the source of the embolus as well as the local obstruction to blood flow. Failure to consider the embolus as evidence of serious systemic disease all too often results in a viable extremity but a patient who succumbs to cardiovascular deterioration.

25 Cases Considered

The following comments are based on a modest experience of 25 cases of arterial emboli during the past three years Successful restoration of blood flow occurred in 92% of the cases in which the emboli were removed within six hours of obstruction. However, the blood flow could be restored in only 74% of the entire group. The longest interval between impaction of an embolus and successful return of pulsatile circulation was 17 days (in a case of popliteal occlusion). The mortality rate was 26%. Amputation was required in one case but four of the six patients who died would have required amputation had they lived

Disorders of the heart were responsible for emboli in 88% of the cases. Patches of ulcerated arteriosclerosis in the aorta or thrombi forming in aneurysms accounted for the remaining 12%. Mitral stenosis was associated with emboli in 66% of the cases. Coronary heart disease with auricular fibrillation was thought to have initiated embolization in 26% of the cases. Mural thrombi from myocardial infarction incited peripheral embolism in 8%.

TABLE I
Location of 25 Arterial Emboli

1.	Aorta	2 cases
2.	Common iliac	4 cases
3.	Common femoral	7 cases
4.	Superficial femoral	3 cases
5.	Popliteal	6 cases
6.	Axillary	1 case
7.	Brachial	1 case
8.	Superior mesenteric artery	1 case
	Total:	25 cases

Pathophysiology of Embolism

The effect of an embolus on the distal arterial circulation depends upon the area occluded, the abruptness of the occlusion and the effectiveness of the collateral circulation.[5] The results of an acute obstruction are probably less than the secondary process which develops. Initially, the obstruction is segmental but becomes extensive with the onset of retrograde thrombosis. Emboli produce complete or incomplete arterial occlusion. They tend to lodge at bifurcations, large branches or sites of partial occluding atheromata. Usually an embolus will progress in the distal circulation as far as the lumen of the vessel will permit.[1,4]

The clinical features of acute embolic ob-

TABLE II
Cause of Death:

1.	Myocardial infarction	2 cases
2.	Multiple emboli	1 case
3.	Cerebro-vascular accident	1 case
4.	Surgical technique	1 case
5.	Superior mesenteric artery thrombosis	1 case
	Total:	6 cases

struction are usually vivid. Following impaction of an embolus in an artery, nerve reflexes produce varying degrees of regional vasospasm. Vasospasm augments the pain which tends to perpetuate spasm. Blood flow distal to the obstruction becomes slow and dependent upon the collateral circulation.[6]

Immediately following obstruction, the distal pressure is low but returns to approximately 40% of the resting level in 15 minutes. If collateral circulation is adequate to provide nutrition of the tissues, ischemic pain subsides and vasospasm disappears. However, all too frequently, the collateral circulation is inadequate and vasospasm and pain cast the die. An inadequate collateral blood supply leads to retrograde thrombosis within 8 to 10 hours. Retrograde clot which extends distally into the small vessels obliterates all evidence of collateral circulation. Venous stagnation is provoked by retrograde clot. Swelling in the extremity heralds the onset of venous clotting.

Untreated Cases

Usually, in untreated cases, gangrene of both lower extremities can be anticipated from abrupt occlusion of the aortic bifurcation. Complete occlusion of the common iliac arteries will produce necrosis in the affected lower extremities to the mid thigh level. Sudden obstruction of the common femoral artery results in gangrene to the low thigh region in approximately 60% of the cases. Occlusion of the femoral artery at the adductor canal or the popliteal artery causes gangrene of the feet or distal leg in approximately 40%. Obstruction of the anterior or posterior tibial arteries results in necrotic changes in only 1% to 2%.[3]

Sudden obstruction of the subclavian artery is rare, and the occurrence of irreversible ischemia is unlikely. Sudden obstruction, however, of the axillary artery by an embolus results in gangrene of the upper extremity in approximately 50%. Abrupt occlusion of the brachial artery at its bifurcation precipitates gangrene in about 30% of the cases. Unless there is obstruction of both ulnar and radial arteries simultaneously, gangrene of the hand is rare. Even though necrosis does not develop, restoration of blood flow should be attempted whenever possible if claudication, trophic changes and other features of chronic ischemia are to be averted.



Picture 1. Left, common iliac embolus and retrograde thrombosis. Embolus is pictured at upper left.

Diagnosis

The diagnosis of an arterial occlusion is seldom difficult. Occasionally the diagnosis will be obscure in ileofemoral thrombophlebitis.[7] The emboli which produce complete occlusion are easier to interpret than emboli which progress from partial occlusion to complete obstruction from periembolic thrombosis. The clinical history is vital in establishing the diagnosis.[9]

Knowledge of previous emboli will suggest embolism. Underlying heart disease with fibrillation, myocardial infarction or mitral stenosis will also incriminate an embolus.

Sudden complete occlusion usually produces pain, coldness, numbness, paralysis and color changes. A history of claudication or evidence of trophic changes such as muscle atrophy, erythema of the foot, loss of subcutaneous tissue, brittleness of the nails and absence of hair on the toes suggests local thrombosis. The best guide to arterial obstruction in the extremities is palpation of selected pulse areas. Temperature changes also aid in localization of the site of occlusion. Obstruction of the terminal aorta results in absent femoral pulses and temperature changes to mid thigh levels bilaterally. Absent pulses distal to the common femoral artery with temperature changes to just above the knee localize the obstruction at the common femoral bifurcation.

When occlusion occurs at the adductor canal, the embolus is usually superimposed on a partially occluding atheroma. Temperature changes to the mid calf level suggest popliteal embolism. Not infrequently, however, atheromata, retrograde clot and vasospasm produce larger areas of color, temperature and tissue changes than would ordinarily be seen.

A majority of emboli to the upper extremities lodge in the axillary artery at the level of the terces major or the brachial bifurcation. The

axillary artery can usually be palpated in the axilla without difficulty. Axillary obstruction produces color and temperature changes as far as the elbow. A bounding pulse proximal to the brachial bifurcation with no pulses palpable in either the radial or ulnar areas suggests a brachial embolus. With brachial artery occlusion, color and temperature changes will be most pronounced in the hand and the distal third of the forearm.[10] In either the upper or lower extremities, if the pulses are absent or faint they should be checked with an oscillometer.

Collateral circulation will be most effective adjacent to the obstruction. Consequently, the temperature and color changes will become more absolute as greater distance from the obstruction is reached. In complete obstruction of the common femoral artery, the foot is cold and cyanotic, but the low thigh may be only cool and pale. Unlike the mesenteric, renal and cerebral circulations, where the physician is not afforded the opportunity for actual palpation and observation, extremity emboli provide ample access for rapid and correct diagnosis.

Treatment

If operation cannot be undertaken immediately, either because of the patient's general condition or the distance over which he must travel, heparin should be given by the attending physician. Late embolectomy is feasible only if distal thrombosis is prevented. No harm will be done if the local physician gives 50 milligrams of subcutaneous heparin. The operating surgeon, however, must be aware of any anticoagulants administered.

Often embolectomy can be performed in the extremities under local anesthesia. Local anesthesia is desirable if the patient can be operated on within eight hours of embolism. If 12 to 14 hours have passed, general anesthesia will probably be necessary for removal of retrograde thrombosis. Blistering and edema make the success of embolectomy unlikely. However, cyanosis, coldness and paralysis do not negate the feasibility of successful restoration of blood flow. Operative arteriography is indicated if the location of the embolus remains obscure. Injection of contrast media in an ischemic leg should be preceded by injection of one per cent Xylocaine®. Fifty per cent Hypaque appears to be the least noxious of arteriographic media. Arteriograms of an ischemic leg, however, should not be taken lightly for muscle and skin necrosis can occur.

A generous longitudinal incision along the affected vessel is elected. The artery is mobilized for proximal and distal control. A longitudinal arteriotomy is made over the embolus. In the severely arteriosclerotic, shreds of media or intima may protrude. Haste at this juncture necessitates an endarterectomy.

After Arteriotomy

Following arteriotomy, the embolus is allowed to extrude. After the embolus has been evacuated, the distal clamp is removed for back flushing. The evidence of back flow is not as significant in acute occlusion as it is in chronic obliterative disease. If there is evidence of retrograde clot, restoration of blood flow will be difficult. Retrograde clot is most pronounced adjacent to the embolus and progresses proximally and distally to the nearest patent branches.

Simply squeezing the extremity from below upward may cause the clot to extrude from the arteriotomy. Catheter suction may also be attempted. An incision is occasionally made along the anteromedial aspect of the knee for retrograde flushing. If there is clot distal to the knee incision, retrograde flushing using a catheter or large needle in the posterior tibial artery may be tried.[2,8]

The same procedures can be invoked for removal of retrograde thrombosis in both upper and lower extremities. If all clot cannot be removed, the venture may not be entirely hopeless, for a mid thigh amputation may be converted to a mid calf amputation. If the embolus is removed within six hours, distal pulses will usually promptly be felt. Anticoagulation is not necessary if pulsations can be felt distal to the embolectomy but if retrograde clot is present, anticoagulants should be added. Heparin is most satisfactory for immediate, effective anticoagulation. The patient should be maintained on heparin until viability of the extremity is assured. The crisis will usually be reached within 96 hours.

Due to morbidity of anticoagulation following arterial surgery, anticoagulation is not employed within the first postoperative week if adequate pulsations have returned to the distal

TABLE III

Operative Results on 25 Arterial Emboli: Successful Restoration of Blood Flow:	
1. Axillary	1 case
2. Brachial	1 case
3. Aorta	0
4. Iliac	4 cases
5. Common femoral	7 cases
6. Superficial femoral	1
7. Popliteal	4 cases
8. Superior mesenteric artery	1 case
TOTAL:	19 cases

vessels. Long term anticoagulation, however, is probably wise in an effort to reduce the occurrence of clot in the heart and the effects of acute arterial occlusion should subsequent embolic obstruction develop.[6,12]

Following return of circulation in an ischemic extremity, reactive hyperemia occurs. Edema may be present for several days. An alteration in the plasma volume and hematocrit may be detected. Hyperemic changes can result in the sequestration of large volumes of fluid in the extremities. Mobilization of this fluid in 72 to 96 hours can precipitate pulmonary edema in the cardiac patient. Frequent examination of the post embolectomy patient is also wise so that other emboli are not overlooked. Persistent abdominal pain must be interpreted as mesenteric ischemia until proven otherwise.[11]

Summary and Conclusions

The surgical management of 25 symptomatic arterial emboli is discussed. Removal of emboli within six hours following embolism resulted in the successful restoration of blood flow in 92% of the cases. The mortality rate was 26%. Restoration of blood flow appears to depend upon prompt diagnosis, effectiveness of collateral circulation and early sound surgical intervention. Immediate anticoagulation is indicated if surgery must be delayed or if retrograde thrombosis is found at the time of surgical exploration. It is usually wise to maintain anticoagulation to reduce the incidence of additional thrombi in the heart or the effects of arterial occlusion should subsequent embolization occur.

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Thrombotic Thrombocytopenic Purpura
Report of a Case

David W. Parsons, M.D.*
Duane N. Tweeddale, M.D.*
Ferris I. Larsen, M.D.*
Madisonville, Ky.

To those diseases known for their mimicry add thrombotic thrombocytopenic purpura. Once established, however, its features are characteristic. Early recognition is essential as all may not be hopeless.

CASE reports of thrombotic thrombocypenic purpura have been occurring with increasing frequency in the literature since 1925 when Moschcowitz first described the syndrome[1]. At present, there are somewhat over 130 recorded cases. The syndrome usually consists of a fulminating course characterized by severe thrombocytopenia with purpura, transient cerebral symptomatology and hemolytic anemia. Such findings are secondary to widespread thrombotic, or thrombotic-like, lesions of small vascular spaces which may occur in almost every organ of the body.

Most early investigators failed to recognize the disease ante-mortem, but recently more cases have been recognized before death. Some of the latter reports have at times suggested that the condition may be consistent with prolonged survival[2], and that significant remissions may be obtained by early recognition and appropriate therapy[3]. Thus, since the discernment of this syndrome may be of more than academic importance, we should like to describe and discuss a characteristic, recently observed case.

Case Report

HISTORY: The patient was a 57-year-old colored female admitted to Hopkins County Hospital on July 11, 1961. Her chief complaint was episodes of generalized weakness, numbness and intermittent local weakness of the arms, involving first one arm and then the other. There also were periods of slurred speech and inability to say the words she desired, with severe headache and vaguely-described visual disturbances often interspersed. Fever or chills were not noted. Her past history included a hospitalization in 1954 for symptoms suggesting angina pectoris associated with an abnormal electrocardiogram. Since then she had had episodic, nondisabling angina.

PHYSICAL EXAMINATION: The blood pressure was 120/80, pulse 72, respirations 20, and temperature 100.2°. She did not appear particularly ill, being lucid and cooperative. The ocular fundi were not remarkable. There were scattered petechiae noted on the palate and on the conjunctiva. There was no significant lymphadenopathy. The neck veins were flat. The chest was clear. The heart did not appear enlarged. There was a soft, poorly transmitted, Grade I basal systolic murmur. Abdominal, pelvic and rectal examinations were unremarkable. The peripheral pulses were palpable. There was no edema.

On neurological examination the cranial nerves were intact. The deep tendon reflexes were present and equal. The Babinski responses were flexor. Sensation was intact to all modalities and coordination was normal. On the basis of the initial history and physical examination, the diagnoses entertained were intermittent insufficiency of the basilar vertebral artery system and subacute bacterial endocarditis with multiple emboli.

HEMATOLOGICAL STUDIES included a WBC of 5,049. The differential count showed 67 segmented leukocytes, 1 stab cell, 1 eosinophil, 21 lymphocytes and 10 monocytes. The hemoglobin was 10 grams, red cell count 2,840,000, hematocrit 26% and sedimentation rate 30 mm/hr. A study of the blood smear showed rouleaux formation, basophilic stippling, polychromatophilia, hypochromasia, sev-

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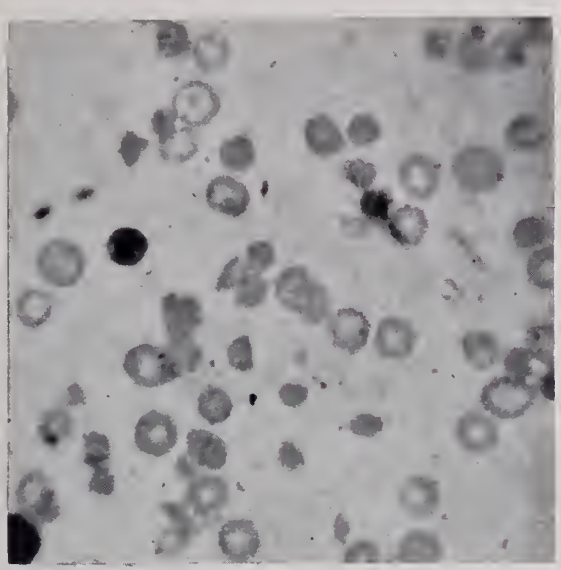


Figure 1. Photomicrograph of a peripheral blood smear taken four days following splenectomy. The nucleated cell is an orthochromatic normoblast. Of special interest are the numerous microspherocytes stressing the hemolytic component of the disease process. Wright's stain. Oil X 1455.

eral microspherocytes, and scattered nucleated red cells (orthochromatic normoblasts) (Fig. 1). The platelets were noted to be markedly depressed. A subsequent platelet count was 13,000 per cu. mm. The sickle cell preparation was negative.

A lupus erythematosus cell preparation was negative. The direct and indirect Coombs tests were negative. The prothrombin time was 87% activity. The bleeding time was prolonged and the clotting time was normal. Examination of the iliac marrow showed intravascular thrombotic lesions, (Fig. 2) increased erythropoiesis, slightly decreased cellularity and a slight decrease in megakaryocytes with deficient platelet production (Fig. 3). In the initial marrow most of the thrombotic lesions did not show significant endothelial proliferation.

BLOOD CHEMISTRY: The fasting blood sugar was 92 mg. %, blood urea nitrogen 20.8 mg. %, cholesterol 294 mg. %, cephalin cholesterol flocculation 4+, and total bilirubin was 1.48 mg. % with direct acting bilirubin 0.52 mg. %. Total protein was 7.2 grams % (Albumin 3.7 and globulin 3.5 grams %) with a zinc turbidity of 24.8 units. Electrophoresis showed increased density in the gamma position (Fig. 4) (see next page.)

Urinalysis was unremarkable except for 4-6 red cells and 6-8 white cells per high-power field in the sediment. No Bence Jones protein

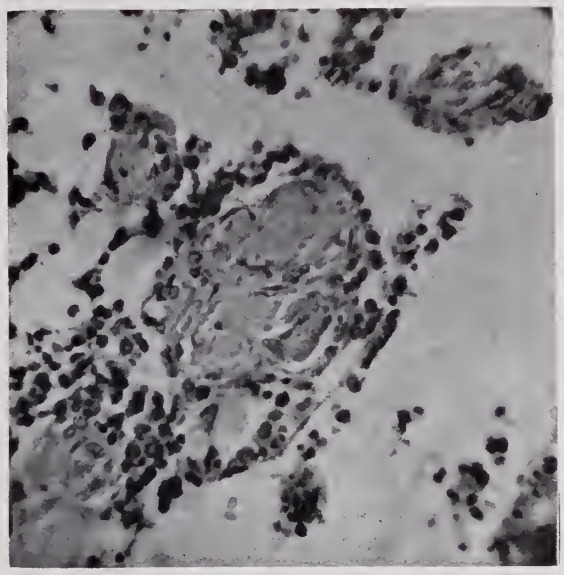


Figure 2. Photomicrograph of a vascular space from the bone marrow. The blood vessel is occluded by a thrombus. The thrombotic process is covered by endothelium and has considerable associated endothelial proliferation. Hematoxylin and eosin. X 645.

was demonstrated. Examination of the spinal fluid was unremarkable. The VDRL was nonreactive.

The EKG showed low voltage in the limb leads and widespread T wave inversion consistent with a nonspecific myocardial abnormality.

X-rays of the skull and chest were not remarkable.

BACTERIOLOGY STUDIES: The following cultures were unremarkable: blood (times

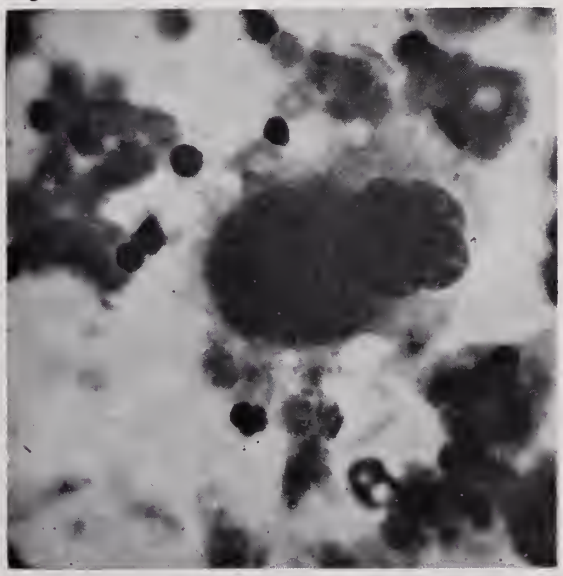


Figure 3. Photomicrograph of a megakaryocyte from the bone marrow. The structure is morphologically unremarkable except that it is not shedding platelets. One can ordinarily identify numerous platelets emanating from the cytoplasm of such cells. Wright's stain. Oil X 1455.



Figure 4. Electrophoretic strip of patient's serum protein showing increased density in the gamma position as contrasted with the normal. Arrow marks gamma position.

2), throat, urine, spinal fluid and stool. Routine febrile agglutinations were negative. The PPD skin test gave a 2 x 2 cm. area of induration in 48 hours.

Her clinical course was characterized by a progressive deterioration. She ran a low-grade, irregular fever with spikes to 102°. Episodes of slurred speech and confusion occurred with increasing regularity along with periods of numbness and weakness of the extremities. She complained of a severe unrelenting headache. Confusion progressing to stupor and unresponsiveness ensued.

Treated With Anticoagulants

Initially, she was treated briefly with anticoagulants on the assumption that the etiology was cerebral vascular sclerosis. As the nature of her condition became apparent, anticoagulants were discontinued and she was placed on Decadron®, 4 mg. every six hours intramuscularly. Despite this, diarrhea, hematuria, and small scattered purpuric lesions on the thighs developed.

On the 11th hospital day, the situation became desperate. Therefore, an emergency splenectomy was performed following the administration of three units of freshly drawn whole blood collected in plastic bags. Although the surgery proceeded without incident, her clinical condition continued to deteriorate and she died on the fourth postoperative day. Platelet counts rose to 46,000 for two days after surgery which was thought to mirror those platelets received by means of the fresh blood transfusions.

The pathological findings of the spleen removed at surgery consisted of multiple foci of extramedullary hematopoiesis with scattered megakaryocytes, multiple foci of lipophagocytosis, and small hyaline-like thrombi in the vascular spaces (Fig. 5). Some areas showed endothelial proliferation (Fig. 6). Similar findings were noted in an accessory spleen. A lymph node was submitted which showed numerous subcapsular intravascular thromboses (Fig. 7). (See next page for Figs. 6 and 7.)

Discussion

This patient demonstrated all of the characteristic major clinical features commonly associated with the syndrome designated thrombotic (or thrombohemolytic) thrombocytopenic purpura. Her presentation as a case of intermittent cerebral symptomatology with episodes of confusion, slurred speech, intermittent numbness and weakness of alternating arms and legs is classic. Such cerebral findings are also seen in patients with intermittent insufficiency of the basilar-vertebral artery system[4] which may lead to difficulty in clinical differential diagnosis especially in the absence of purpura as noted early in our case. Cases of thrombotic purpura do not necessarily present as an acute process but may have long initial periods of cerebral symptoms with or without evidence of purpura or recognizable hematological abnormalities.[5] Some patients may thus receive anticoagulants, as did ours briefly, when they should be receiving massive doses of steroids and possibly an early splenectomy. The recent emphasis on the recognition of these intermittent cerebrovascular syndromes

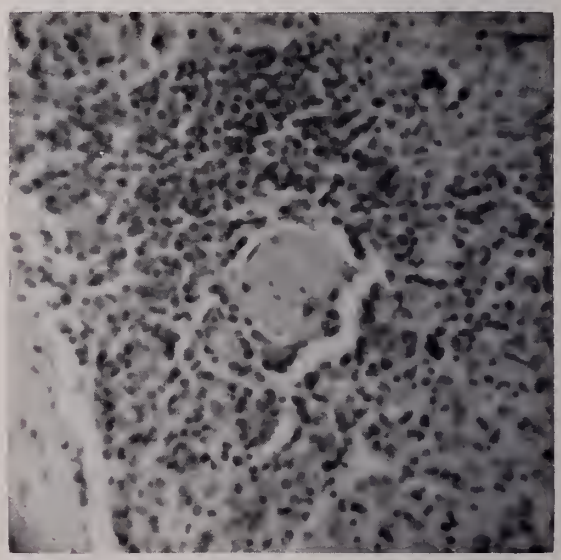


Figure 5. Photomicrograph of a vascular channel in the spleen removed at surgery. The vessel lumen is occluded by characteristic hyaline material. There is no significant endothelial proliferation. Hematoxylin and eosin. X 645.

accentuates the importance of an awareness of thrombotic thrombocytopenic purpura with such symptomatology.

The second important feature we observed was marked hemolytic anemia. This is recognized on a blood smear in which nucleated red cells, microspherocytosis and polychromasia are seen. This highlights our feeling that in all "routine" hematologic examinations in which the hemoglobin is less than 11 grams, a peripheral blood smear should be examined by an experienced observer. In fact, that procedure gave us the first inkling that we were dealing with a hemolytic anemia and thrombocytopenia. Coombs tests in this condition are, with few exceptions, negative. The association of a severe, acquired hemolytic anemia and a thrombocytopenia with a negative Coombs test should raise the suspicion of thrombotic thrombocytopenic purpura. Jaundice and reticulocytosis constitute further evidence of a hemolytic process.

Purpura May Occur Late

As in our case, the purpura and hemorrhagic manifestations of thrombotic thrombocytopenic purpura may occur late in the course and may constitute only a minor part of the over-all symptomatology. In some cases, however, hemorrhage and hemorrhagic manifestations have been the presenting problem.[6, 7] Nonetheless, basically, the purpura is properly classified as

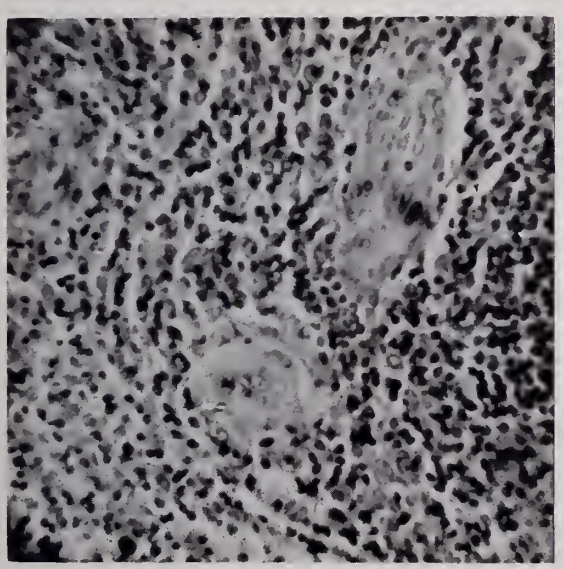


Figure 6. Photomicrograph of a vascular channel in the spleen. The vessel lumen is occluded by the basic thrombotic process. In addition, there is marked endothelial proliferation, a not uncommon feature in thrombotic thrombocytopenic purpura. Hematoxylin and eosin. X 645.



Figure 7. Photomicrograph of a vascular channel from the capsule of a lymph node removed at the time of splenectomy. The lumen is almost completely replaced by a thrombus. Note once again how the process is endothelial covered and seems to originate in the vessel wall. Hematoxylin and eosin. X 645.

thrombocytopenic and must be differentiated from idiopathic or other varieties when other characteristic signs are not fully developed. These would include thombocytopenias associated with myelophthisis, hypersplenism, platelet auto antibodies and drug induced thrombocytopenias.

Bone marrow sections showing the typical intravascular hyaline thrombi seem the most incisive diagnostic tool in differentiating this thrombocytopenia from other types.[8] Indeed, this technique is becoming an increasingly valuable, readily obtainable method in the diagnosis of many obscure conditions.[9] The presence or absence of platelet shedding by megakaryocytes is apparently not of differential diagnostic value as there have been diverse observations reported on this point.[10, 8] The vascular and allergic purpuras should present no problem in differential diagnosis as thrombocytopenia is not prominent.

Protean Syndromes

This group of purpuras associated with abnormal serum proteins may present as confusing, protean syndromes.[11] These include Waldenstrom's macroglobulinemia, purpura hyperglobulinemica, cryoglobulinemia and multiple myeloma. In our case, abnormalities of the serum proteins were demonstrated in that she had positive cephalin flocculation, elevated zinc

turbidity and increased density in the gamma position electrophoretically. Others have made similar observations.[8] This would categorize thrombotic thrombocytopenic purpura with those states showing hyperglobulinemia, always a diagnostic signal of an exotic condition.

Many cases have also shown biologic false positive serological tests for syphilis, a not uncommon finding in hyperglobulinemic states. The aforementioned protein abnormalities seen in thrombotic thrombocytopenic purpura are shared with several collagen diseases, notably lupus erythematosus. Pathological findings typical of each condition have coexisted or have developed in the course of reported cases.[12, 13]

Ante-Mortem Diagnosis

Ante-mortem diagnosis can be established by studying tissue sections from any one of numerous sites in the body, such as the bone marrow, skin, lymph nodes, spleen, etc. Such is a reflection of the widespread nature of the basic "thrombotic" process. From a strict morphological viewpoint, the disease does not appear to be thrombotic but mural with secondary changes of endothelial proliferation. Indeed, our first bone marrow aspiration revealed subendothelial pink homogenous masses without significant endothelial proliferation. At postmortem the bone marrow sections showed considerable endothelial proliferation, a finding that could possibly represent aging, or repair, either spontaneous or secondary to steroid therapy.

The clinical course of thrombotic thrombocytopenic purpura as evidenced by those cases reported in the literature may vary from an abrupt, fulminating illness, as in our case, to a prolonged, bizarre, remitting, protean disease in which the characteristic pathological findings are occasionally found in retrospect from unrelated material.[2]

Prolonged Course

In spite of the pessimism that has appended earlier descriptions of this disease, it now appears that it is consistent with a prolonged course and that a significant remission can be obtained from specific therapeutic maneuvers. These have largely been obtaind by the use of massive steroid medication combined with splenectomy,[3] although either procedure utilized alone has been observed to produce a remission.[14] A patient treated with fresh blood transfusions alone apparently sustained a remission.[15] Since this disease may not be as rare as originally suspected and may have a therapeutically alterable course, it is to be hoped that widespread awareness of its characteristics will result in earlier diagnosis and a generally more favorable outlook.

Summary

A recently observed fulminating case of thrombotic thrombocytopenic purpura which was unresponsive to steroids and splenectomy is described. The important clinical characteristics of intermittent cerebral symptoms, hemolytic anemia, thrombocytopenia, fever and serum protein abnormality are demonstrated. Several differential diagnostic points are stressed. The pathognomonic pathological changes are described and several recent attempts at treatment are outlined.

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The Diagnostic and Prognostic Value of Serial Alterations of Plasma Cholinesterase and Transaminases (SGO-T and SGP-T) in Patients with Hepatic Coma

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An evaluation of serum glutamic oxaloacetic transaminase (SGO-T) and serum glutamic pyruvic transaminase (SGP-T) is useful in the determination of hepatic necrosis. Their increased activities offer information on the course of hepatic coma.

THE ACTIVITIES of serum glutamic oxaloacetic transaminase (SGO-T) and serum glutamic pyruvic transaminase (SGP-T) are increased whereas serum cholinesterase is depressed in parenchymal hepatic diseases. As a result, the evaluations of these enzymes are useful in the determination of hepatic necrosis and in following the clinical assessment of specific and conventional therapy of hepatic coma.

Recent Investigations

Recent investigations have disclosed that the distinction of impending or deep hepatic coma is determined more reliably and practically by characteristic psychiatric findings than by measurements of elevated blood ammonium-nitrogen, serum cations, plasma amino acids, blood metabolites, plasma glutamene and an abnormal electroencephalogram.[1-9]

It is the purpose of this investigation to compare serial measurements of serum cholinesterase, SGO-T and SGP-T in 10 patients with clinically established hepatic coma and to discuss the use of these enzymatic determinations as a prognostic aid for the clinician.

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Materials and Methods

The patients and controls were investigated by diagnostic needle biopsy of the liver and the following hepatic function tests: Bromsulfalein dye retention at 45 minutes; direct and indirect serum bilirubin; thymol turbidity; plasma alkaline phosphatase (Bodansky method); cephalin-cholesterol flocculation; prothrombin time; serum isocitric dehydrogenase; zinc sulfate turbidity; serum iron; serum leucine amino peptidase, and serum albumin and globulin.

A simple colorimetric method of Reitman and Frankel, the accuracy of which is comparable to the established technique of Karmen and Wroblewski and LaDue, was employed for the determination of SGO-T and SGP-T.[10-16] Estimation of the activity of cholinesterase in the plasma was performed by the simplified technique of Biggs, Carey and Morrison.[17] The results obtained by this method correlate with the technique of Michel and others.[18-26]

Cirrhosis Of The Liver

All the patients had morphologically established cirrhosis of the liver, either of the portal or postnecrotic variety. The routine treatment of hepatic coma employed in these patients was absolute restriction of nutritional protein, intravenous fat-concentrated-dextrose solution (Lipomul), multiple vitamins and neomycin, four grams per day, through gastric intubation, correction of electrolyte and water imbalances, oxygen tent when necessary, and the Sengstaken-Blakemore nasogastric tube to tamponade bleeding esophageal varices. In only two cases was corticosteroid therapy used as a "desperation measure." It had been found that

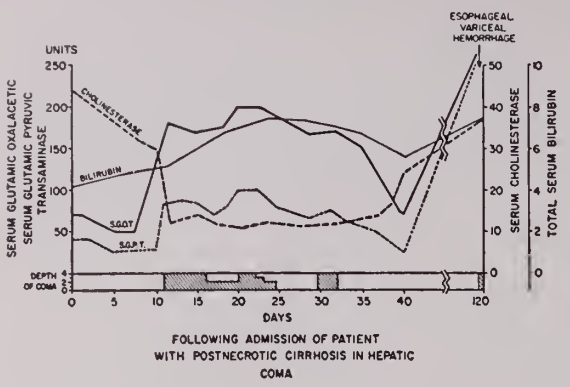


Figure 1

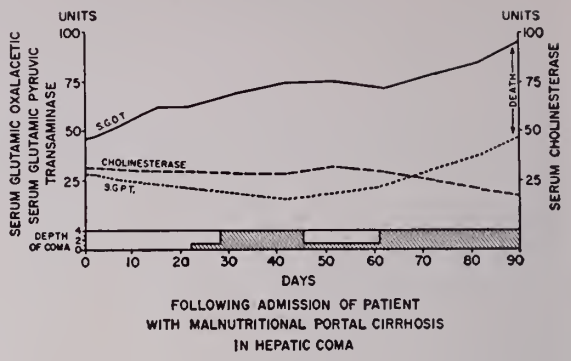


Figure 2

the latter treatment usually delayed death from hepatic coma.

Results

The serial measurements of these tests did not offer any significant diagnostic aid in following patients in hepatic coma. As a matter of fact, observations of the established neuropsychiatric clinical findings were more reliable.

The serial activities of SGO-T, SGP-T and plasma cholinesterase were found to be reliable, conformable indices of clinical approaching recovery or approaching death in patients with hepatic coma or hepatocerebral intoxication. Abnormal activity of these tests is indicative of hepatocellular degeneration, confirming the observations of Donato and others.[28-31] The occurrence of hemorrhagic esophageal varices, hepatocellular or regurgitative jaundice, ascites or hepatosplenomegaly did not correlate with abnormality of these serial enzymatic tests. Progressively inverse proportions of serum transaminase and plasma cholinesterase, therefore, implies a poor prognosis (Figures I and II). Deeper, lethal hepatic coma also correlates with more abnormal activity of these tests, (Figure III). Resolution of hepatic coma, likewise, is indicated by the tests returning toward normal. This observation suggests that serial determination of these enzymatic tests may serve as an adjunctive measure with the neuropsychiatric findings in following the clinical course of patients with hepatic coma.

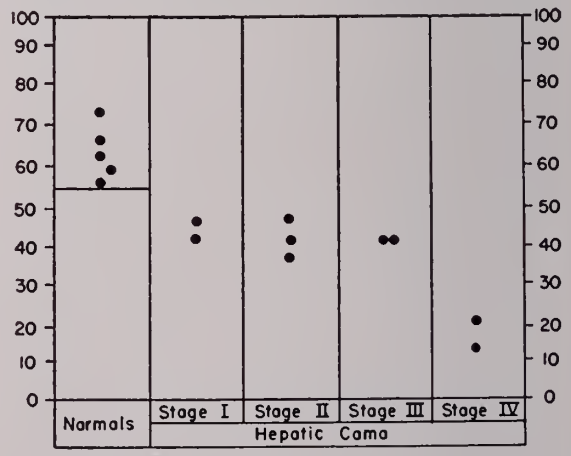
A study of the serial plasma cholinesterase, SGO-T and SGP-T in 10 patients in various stages of hepatic coma has demonstrated that these enzymatic activities offer selective evidence of hepatic parenchymal function. The colorimetric determination of these enzymes every second or third day in the course of hepatic coma affords the clinician more practical and reliable information than, for example, conventional hepatic-function tests.

Discussion

The clinical stages of hepatic coma have been described by Webster and Davidson.[27]

Serum glutamic oxaloacetic transaminase was first discovered by Braunshtein and Kritsman in 1937.[32] Serum glutamic pyruvic transaminase had been determined to be an extremely sensitive criterion of hepatocerebral integrity.[12,13] However, these and other enzymes found in serum are not "organ-specific," according to recent opinions.[16]

The activity of transaminases has been determined in both normal and diseased hepatic parenchymal cells.[28,30] None of the conventional hepatic function tests available actually provides a satisfactory index of the degree of hepatic cell necrosis. The activity of serum



SCATTERGRAM DEPICTING SERUM CHOLINESTERASE IN HEPATIC COMA

Figure 3

transaminase and plasma cholinesterase were more useful than the level of serum iron in patients with hepatic coma.

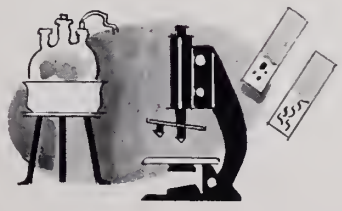
It has been noted that statistical correlation of histological appearance in liver biopsy material and SGO-T and serum iron levels showed excellent correlation of hepatic necrosis but no significant correlation with either bile stasis or periportal inflammatory reaction.[33] The level of serum transaminase activities appears to be extremely sensitive of hepatic injury, correlating with the extent of damage to the hepatic cells.[28] Plasma cholinesterase is reduced in hepatic parenchymal disease. Investigators have found this test easily performed and reproducible, to be of value in differentiating obstructive from hepatocellular jaundice, and, when performed serially, of value in the prognosis of cirrhosis and acute hepatitis.[19,21,24]

Summary

Increased activities of serum glutamic oxalacetic acid transaminase and serum glutamic pyruvic acid transaminase and decreased activity of plasma cholinesterase, when determined serially, offer adequate and practical biochemical information in following the course of hepatic coma.

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Hypertension and Blood Pressure in the Arms

Sidney Roston, M.D.*
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High blood pressure in the arms does not necessarily mean high pressure in the central arteries. Cerebral symptoms which improve with reduction in pressure may be the best early clue to significant central hypertension.

THE clinical problems which arise in the evaluation of essential hypertension require handling from day to day on the basis of the incomplete knowledge which is available. The decision as to whether or not hypertension requires treatment is frequently difficult, particularly in elderly individuals, in whom its course is commonly benign.[1]

The immediate aim of treatment is the lowering of blood pressure in the arms, where measurement takes place. Proof of beneficial effects of the lowering of brachial blood pressure frequently cannot be found over the short term and may require prolonged observation and statistical techniques. Thus, the fact that the continuous and considerable expense of long term anti-hypertensive therapy discourages many asymptomatic patients would not be unexpected. The three cases in this report may throw light upon some fundamental problems in the complex field of hypertension.

Case Reports

Case 1. A 77-year-old white female complained of frequent sharp, brief pains in the occipital region of her head of several months' duration. In addition, she felt that her memory for recent events and her mental acuity as a whole were worsening rapidly.

On examination, she was a thin, alert and active woman who did not appear ill. The casual sitting blood pressure[2] was 120/80 in the left arm and 240/120 in the right arm. The radial and ulnar pulses were equally full in both wrists, the pulse rate being 72. The fundi showed class 2 changes in the Keith-Wagener classification. The heart was within normal limits. The physical examination was otherwise negative. Routine laboratory studies, including chest x-ray, electrocardiogram and blood urea nitrogen, were normal.

Blood Pressure Stabilized

The patient's blood pressure was stabilized over a three-week period on 30 mgm. of guanethidine and 5 mgm. of benzydroflumethiazide each morning. Not until the blood pressure in her right arm dropped below 200 systolic in the sitting position did she notice an improvement in her cerebral symptoms. When her blood pressure finally maintained a plateau at 175/90 in the right arm, she felt completely well. At that time, the blood pressure in her left arm was 116/77, and the wrist pulses remained full there.

Case 2. A 78-year-old white female awoke one cold morning in December 1960 after eight hours of normal sleep with a severe steady frontal headache, generalized weakness and frequent momentary lapses into semi-consciousness. She had been taking Serpasil for mild hypertension for nearly one year. She had for many years had a Grade 2 rough long systolic murmur over the precordium, loudest at the aortic area, transmitted into the neck. Her chest x-ray had, several months previously, shown calcification in the aortic arch.

On examination, she was taut and frightened. She was shivering, but her moderate mental confusion prevented her from noticing this fact. The temperature of her poorly insulated and inadequately heated bedroom was 58° F. She answered only simple, direct questions clearly,

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complex thought processes not being attempted. The neurological examination was otherwise unremarkable. The blood pressure in her left and right arms was 250/125 and 240/125, respectively, the pulse 80 per minute and regular.

Action Taken to Warm Patient

Vigorous action was taken to warm the patient by use of blankets and a hot water bottle. Within 20 minutes, her shivering ceased. She became relaxed and increasingly responsive. The blood pressure in her left arm dropped rapidly to 190/100. She recovered completely from the acute episode over the next several hours.

Case 3. During routine examination of a 47-year-old colored female, blood pressure levels of 230/130 in the left arm, and 220/125 in the right arm were found. She asserted that she had no headaches or dizziness and felt completely well. The remainder of the physical examination was normal. Chest x-ray, electrocardiogram, intravenous pyelogram and laboratory studies were unremarkable.

She was placed on gradually increasing doses of guanethidine and benzydroflumethiazide. On 30 mgms. of the former and 5 mgms. of the latter each morning, her pressure in the sitting position became stable at 150/100 in the left arm and 145/98 in the right arm. As the pressure decreased she noted a corresponding increase in her vigor, her sense of well being and her optimism. She asserted that, in retrospect, she realized how easily and often fatigue and emotional upset had occurred during the period of untreated hypertension.

Comment

The definition of hypertension remains controversial. On the one hand, two distinct populations, one with normal and the other with high blood pressure, may exist.[3] On the other hand, the distribution of blood pressure in the society may be continuous over the whole pressure range, with hypertension signifying an excess of the brachial pressure over an arbitrary level.[4]

The complexity of the problem in the population at large is not surprising in view of the frequent difficulty in deciding what the meaningful blood pressure is in a given individual. Not only do the emotional state, activity, food intake and environmental conditions modify the blood pressure in a given arm,[2] but, basic differences between the pressure recorded in the two arms by either the direct or indirect techniques may exist, as well.[5] These differences are compatible with the theoretical conclusion that the brachial and aortic pressures may vary independently of each other.[6]

Which brachial pressure in Case I most closely represents the values at the heart and brain would be impossible to decide unequivocally without intra-arterial measurements in the aorta and carotid arteries. The lower value may be due to arterial narrowing of arteriosclerotic origin, despite the relative fullness of the brachial, radial and ulnar pulses. Conversely, the higher value may be an exaggeration, because of the rigidity of the brachial artery wall, of the commonly observed excess of the brachial over the aortic pressure.[7]

Insurance Underwriters

Insurance underwriters have demonstrated that, over the long term, shortening of life accompanies high blood pressure in the arms. Over the short term, however, not only is evaluation of the blood pressure level in the central arteries difficult, but determination of the effect of arterial hypertension upon vital body organs may be difficult, as well. Cardiac enlargement by X-ray and electrocardiographic changes compatible with left ventricular strain demonstate the effect of high pressure in the ascending aorta. However, abnormal cardiac findings occur relatively late in the course of hypertension.[8] Grades 1-3 fundic changes in the Keith-Wagener classification, are highly non-specific for hypertension in the presence of arteriosclerosis.[2]

Other Evaluations Needed

Other means of clinical evaluation of the early systemic effects of pressure elevation, in the presence of normal cardiac and renal behavior, are necessary. Subjective symptoms —headache, dizziness and loss of mental acuity—may, by default, assume an important role in such early evaluation. Considered by themselves, these symptoms are of little specific value in diagnosis.[2] Together with brachial hypertension, they may point to, but do not

prove the existence of, increased pressure in the cerebral arteries.[2] They are of increased significance when they disappear with actual decrease in blood pressure and not immediately after the beginning of treatment.

The three cases of the present report demonstrate various patterns of subjective symptoms in hypertension. In Case 1, the presence of head pain and impairment of thought processes suggests that the high reading of brachial blood pressure is closer to the cerebral arterial pressure than the low value. The disappearance of the symptoms with decrease in the right arm pressure strengthens this conclusion.

Case 2

Case 2 shows a direct parallelism between the cold-induced increase in brachial pressure and changes in symptoms and behavior.

Case 3, on the other hand, demonstrates that a hypertensive patient may become aware of cerebral symptoms only with lowering of the brachial pressure toward normal levels.

The present impasse in the definition and evaluation of hypertension may well arise from the uncritical use of the brachial artery pressure as the independent variable. In many cases, the meaningful arm pressure either cannot be clearly established or may differ widely from the pressure in the central arteries. What is needed is a simple indirect method for the clinical determination of pressure in the aorta and its cerebral and renal branches.

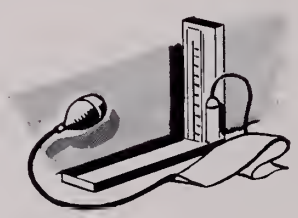
Cardiac and renal abnormalities which can be diagnosed by present techniques occur relatively late in the course of hypertension. By default, despite their inexactitude, cerebral symptoms which improve with reduction in pressure may frequently be the best early clue to the existence of significant hypertension in the central arteries.

Summary

Many problems in hypertension may result from the use of the brachial artery pressure as the independent variable. When wide differences exist between the pressure in the two arms, for example, evaluation of the actual pressure in the aorta and cerebral and renal arteries may be difficult. Because of the slow development of cardiac and renal changes, cerebral symptoms which improve with reduction in pressure may frequently, despite their inexactitude, be the best early clue to the existence of significant hypertension in the central arteries.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Medial Arteriosclerosis Resulting in Factitious Hypertension

Maurice M. Best, M.D., and Charles H. Duncan, M.D.*

MEDIAL calcinosis is characterized by endothelial hyperplasia and extensive calcification in the media of large and medium-sized arteries. The calcification occurs in finely divided deposits and may be quite striking on the roentgenogram. This lesion was first described by Monckeberg, who also stated that it was not often associated with atheroma formation.[1] The finding of medial calcinosis in a patient is usually considered to be of little clinical significance since it does not in itself indicate the presence or absence of an occlusive process in the artery involved.[2] The division into presenile and senile medial calcinosis seems to serve no useful purpose since the etiology is incompletely understood and the generally favorable prognosis does not differ with the sex or age of the patient.

Involvement of Arterial Wall

Severe involvement of the arterial wall with medial calcinosis might be expected to result in a loss of elasticity of the artery and could result in an erroneous high estimation of arterial pressure by conventional methods. Such a finding was present in the following patient; the calcification in the arterial wall was attributed to medial calcinosis of the Monckeberg type.

G. J. K., 84-year-old, Caucasian male, was admitted to the medical service from the emergency room of the Louisville General Hospital with the provisional diagnosis of congestive heart failure due to hypertensive cardiovascular disease (malignant phase). The admission report stated that his "blood pressure was too high to measure."

The patient, a good historian, stated that he had been troubled with increasing shortness of breath for the past two months. At first the dyspnea was present only on exertion but now also occurred at rest. During the past two weeks the shortness of breath was accompanied by burning chest discomfort. Dependent edema was first noted the day of admission.

Family History of Longevity

The family history was characterized by longevity. The father and mother living until their late 70's with death from unknown causes. Of 11 siblings, 10 were alive. There was no history of diabetes mellitus. An appendectomy was performed in 1935. Otherwise the patient had enjoyed good health and rarely consulted a physician.

Physical examination revealed a pulse rate of 92 and a respiratory rate of 26 per minute. The following abnormal findings were recorded: Bilateral lens opacities, crackling rales in the lung bases bilaterally, cardiac enlargement with a systolic murmur suggestive of aortic stenosis, moderate pitting edema of the lower extremities.

The peripheral arteries felt hard and beaded but their pulsations were palpable. Repeated attempts to obtain the arterial blood pressure in the upper and lower extremities were unsatisfactory. It was impossible to inflate the cuff of the conventional sphygmomanometer sufficiently to cause the tapping sounds heard through the stethoscope to disappear nor was it possible to obliterate the radial pulse by the blood pressure cuff. There seemed to be some

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Figure 1. Roentgenograms of the upper arms. Very extensive finely divided diffuse calcification is noted throughout both brachial arteries. The changes are typical of medial calcinosis of the Monckeberg type.

muffling of the sounds in the range of 150 to 160 mm. Hg.

The attending staff recorded the blood pressure as 300/160 mm. Hg. A direct blood pressure recording through an intra-arterial needle at this time was 130/80 mm. Hg.

The following laboratory determinations were within the range of normal: Complete blood count, urinalysis, serum uric acid, creatinine, sodium, potassium, glucose, calcium, phosphorus, carbon dioxide content, chloride and urea nitrogen. Prothrombin activity, SGOT (x 5), and alkaline phosphatase were also normal. Serum proteins were reduced to 5.7 gms. per 100 ml.

Serum Cholesterol

Serum cholesterol (Abell method) was 172 mg./100 ml. and serum triglycerides (Van Handall and Zilversmitt method) were 100 mg./100 ml. Both of the values were within the normal range for our laboratory. The electrocardiogram revealed marked left ventricular enlargement with subendocardinal ischemia.

Roentgenograms of the chest showed calcification in the region of the aortic valve but very little change in the aorta. Films of the upper (Figures 1 and 2) and lower extremities revealed very extensive medial calcinosis of the large arteries.

The final diagnosis was congestive heart failure due to arteriosclerotic heart disease with aortic stenosis. The clinical response to digitalis and diuretic agents was satisfactory and the patient was discharged to a nursing home.

Discrepancy Found

Some discrepancy is commonly found between the direct arterial pressure and the indirect blood pressure as measured by the pneumatic cuff. In a study involving for the most part young adults, Regan and Bordley found that if the arm is small the clinical estimation of blood pressure is apt to be too low, while if the arm is large the clinical estimate of both systolic and diastolic pressure is likely to be too high. They noted errors as high as 30 mm. Hg. in either direction. They also suggest that in an older age group the accuracy of ausculatory measurements might be adverse-



Figure 2. Roentgenograms of the forearms. Very extensive medial calcinosis is again demonstrated. The diffuseness of the calcification plus its finely divided appearance is characteristic and differs from the large localized plaques found in arteriosclerosis obliterans.

ly affected by changes in rigidity of the artery wall.[3]

The degree to which vascular changes may influence the accuracy of blood pressure determination is a matter of considerable clinical importance. Janeway studied the problem in 1915 and concluded that in the vast majority of patients the resistance offered by the vessel wall to external compression is negligible but he also noted that in a few patients such resistance is clearly the cause of overestimation of the actual blood pressure by the sphygmomanometer.[4] Master has recently reviewed the subject and concluded that calcification of considerable degree in the arterial wall is without appreciable effect on the compressibility of the vessel wall and hence on the blood pressure determination.[5]

Our data would indicate that on occasion very significant artifacts may occur in the measurement of the blood pressure by conventional means in patients with extensive medial calcinosis of the artery wall of the Monckeberg type. The prevalence of such phenomena is unknown but it may be more common than usually considered.

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SPECIAL ARTICLES

Medical And Hospital Care Programs In Canada—1962

D. W. Penner, M.D.

Winnipeg, Manitoba, Canada

ON June 18th, 1962, Canada held a Federal election. Medical care programs have become one of the key issues in the election campaign of all political parties running for office. Possibly because of the personal interest to the electors and to the currently existing situation in Saskatchewan, this issue is receiving a very large amount of time and space in all media of communication.

More Than 10 Years Old

Historically, Government sponsored medical care programs, other than in very limited areas such as tuberculosis and mental disease, date back for more than ten years. At that time Saskatchewan had a fairly comprehensive compulsory Government sponsored hospitalization insurance plan in effect. This was followed by a Federal Government hospitalization and diagnostic services plan in which the Federal Government undertook to pay one-half the cost of any Provincial hospitalization plan. Since matters of health are controlled by the Province, the option of accepting this aid was left to each Province, and now all Provinces in Canada have a prepaid compulsory hospitalization and diagnostic plan in operation, the Province of Quebec joining only one year ago. Significantly and not generally appreciated is the fact that this plan was actually a combined hospitalization and medical care plan since it included the payment of professional services of pathology and radiology done in hospitals for both in-patients and the majority of out-patients.

Initially, large sums of money became available to hospitals and the Government "controls" were very loose or almost non-existent. Services and salaries markedly improved. Most pathology and radiology services received markedly increased benefits from these additional funds. The cost to the Government rose very rapidly and the budgets increased by more than 100% in one or two years of operation. The continued rapid increase in cost soon became a major portion of the total Provinical budgets. As was inevitable and predictable, attempts were made to hold the budget down and an increasing control by the Government, mainly through the budget, became apparent. Meanwhile, the volume of work, particularly in pathology, continued to increase and there were insufficient funds to meet the demands. This is the state in which many hospitals and pathologists find themselves today. The situation is not yet critical, but many problems and points of friction are rapidly becoming apparent.

Next Milestone

The next important milestone in the field of health in Canada was again introduced in Saskatchewan. The major platform of the Saskatchewan Government in its Provincial election in June, 1961, was the introduction of a comprehensive compulsory medical care program. This was introduced by the Premier, Mr. Douglas, who had also introduced the hospitalization plan. A considerable but rather ineffectual effort was made by the medical profession to defeat or alter this plan. The Government was returned to office, although on less than one-half the popular vote. On the insistence of the medical profession, a Commission was set up to study the entire field of medical care and advise the Government. Meanwhile, tentative

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* *Doctor Penner is American Society of Clinical Pathologists councilor from Canada. This appraisal of the government-sponsored health program in Canada is reprinted from the monthly publication of the ASCP. He will address the KSMA House of Delegates September 17, just prior to the annual meeting.* *(See page 880.)*

legislation was drawn up. The Commission brought in a majority report endorsing complete compulsory medical care. The minority report which included the medical members strongly advocated the use of the existing insurance plans with Government aid only on a basis of economic need. It was pointed out that the cost of this would be approximately one-third of a complete program.

Vigorous Protests

In spite of vigorous protests by the medical profession, the Saskatchewan Government passed a medical care Act which was to go into effect on January 1st, 1962, subsequently postponed to become effective April 1st, and finally on July 1st, 1962. Meanwhile, at the request of the Canadian Medical Association, the Federal Government set up a Royal Commission to study and advise on the needs of medical care at the National level. This Commission instituted a vast fact finding program and is presently hearing innumerable briefs from any interested organization or individual. A good deal of general interest has been generated and much coverage has been given these hearings, in particular the briefs of "organized" medicine and labour. Each Provincial Government has also submitted a brief and of these only the Saskatchewan brief has endorsed a complete comprehensive compulsory medical care plan.

Mr. Douglas, in the meantime, has become the National leader of a newly formed political party, this party being that of the former Saskatchewan Government (Co-operative Commonwealth Federation) and organized labour. It is now known as the New Democratic Party.

The Saskatchewan situation has become critical. The medical profession has shown surprising consolidarity in its opposition to co-operate with the Government plan. The several postponements as to effective dates were due in part to the fact that they could not get the required two doctors to sit on the Committee which was to set up the machinery.

The Act, as it now stands, is a comprehensive compulsory insurance plan paid in part by direct annual dues and the remainder being covered through an increased sales tax. Estimated cost of this and the hospitalization plan exceeds 50% of the total Provincial budget. Payment to doctors is on a fee-for-service based on present fee schedules with free choice of doctor and consultant. The basic issue—that of loss of personal freedom of the doctor because the Government now becomes the monopolistic purchaser of all medical services, is difficult for the people as a whole to understand. Since practically every rule and regulation can be changed by the Government by an order in Council, the Government can exercise any and all control of any aspect of the practice of medicine it wishes. The significance of this is not generally seen by the public and is deliberately underplayed or distorted by the Government and those who advocate the plan. The doctors are being made to appear as a greedy, power hungry, minority group, who, because of their unique services refuse to co-operate in a plan which would obviously benefit suffering mankind.

The doctors in Saskatchewan are extremely well organized and with almost no exception will provide emergency service in hospitals only after July 1st, 1962. A considerable number of doctors are leaving the Province but the majority are prepared to stay and see it through. They are convinced that the Government cannot force them to become servants of the state and that the people of Saskatchewan will support them. The Government is equally adamant that they will introduce the plan and that the doctors will bow to social justice and fulfill their sacred oath to care for the sick.

The Saskatchewan Government is actively advertising for g e n e r a l practitioners in the United Kingdom, offering a guaranteed $10,-000.00 per annum income. The Attorney-General has also recently suggested that doctors who refuse to look after the sick are breaking a contract under the new Act and, therefore, are subject to prosecution. Injunctions and legal test cases will no doubt be instigated.

Public feeling is running high. Many petitions and delegations have been instituted both for and against the Act. Several key members of the Government, including the previous Minister of Health (who drew up the legislation), have resigned in protest over the Government attempts to force the medical profession into participation rather than work out some acceptable plan.

One has the feeling that much of the support given the medical profession by the public at large is due to a fear of loss of a vital personal service rather than supporting the fundamental principle of individual freedom.

Prescriptions For Improving Our Language Usage

Francis M. Massie, M.D.
Member, Advisory Committee to the Editor

FOREWORD to publishing this in The Journal of the Kentucky State Medical Association.
We have made almost all the errors listed below, hence it is with no feeling of superiority that we submit these common mistakes with correct forms. We hope this will be helpful.
Each of us can think of other mistakes in spelling, grammar and syntax.
We realize that language is a living, growing thing and that forms not acceptable to the educated 50 years ago may be acceptable now. Nevertheless, we are certain it is well to set up "some standards to which the wise and honest may repair."

(1) Some Common Misspellings

Desiccate	not	Dessicate
Embarrass	not	Embarass
Harass	not	Harrass
Navel	not	Naval
Permissible	not	Permissable
Reversible	not	Reversable
Pruritus	not	Pruritis
Supersede	not	Supercede
Inoculate	not	Innoculate
Abscess	not	Abcess
Absent	not	Abscent

(2) Some Bastard Words

Preventive	not	Preventative
Regardless or Irrespective	not	Irregardless

(3) Some Definitions

Epitome means brief resume of; it does *not* mean the height of or the perfect example of.
Fruition means the enjoyment of and secondarily the completion of or fulfillment of.
This second definition is not given in the Oxford English Dictionary.

(4) A Common Error

Between you and I
He did it for you and I
Correct: Between you and *me*
He did it for you and *me*

(5) Words Commonly Confused

Lose, lost; lost always a verb
Loose, usually an adjective; opposite of tight; occasionally a verb = untie, "Doctor, will I loose my child?" means "Doctor, will I untie my child?"

Lie as a verb, lay, lain
as a noun = untruth, or technical in golf
Lay, laid, laid, a verb (transitive) as, "The goose that laid the golden egg." "I lay the book on the table."
Occasionally a noun, poetry.
Never: "I was laying around," "The book was laying on the table."

Suspect, usually a verb, "I suspect he did it." not "I expect he did it."
Occasionally a noun, as "The suspect was tried by jury."
Occasionally an adjective, "Your conduct is suspect."
Suspicion always a noun, "Suspicion rests on him" never "I suspicioned he did it."

Like as a verb, "They like each other"
as an adjective, "On like occasions"
as a preposition, "Like me, he was angry."
Never as a conjunction, ". . . *like* a cigarette should" is poor English.
As well say, "We still brew good *like* we useter could."

Good and Bad are adjectives
"I feel good" or "I feel bad"
Well and Badly are adverbs
Some confusion here because Well is occasionally an adjective as, "She rarely has a well day."

Different *from* is preferable to
Different *than* though either is correct.
To differ *from* is better than
To differ *with* though either is correct.

(6) Decades of Life

Years	0-10	10-20	20-30	30-40 etc.
	1st	2nd	3rd	4th

Anyone 12 years old is in the second decade, thus anyone 23 years old is in the third decade; anyone 61 years old is in the seventh decade, etc.

(7) Latin Forms

Per primam never	per primum
Singular	*Plural*
Medium	Media (this is always plural)
Diverticulum	Diverticula (never -li or -lae)
Viscus	Viscera (never viscerae)
Adnexum (never adnexium)	Adnexa (never -ae)
Labium majus minus	Labia majora minora
Agendum (rarely used in this singular form)	Agenda (never -ae)

(8) Greek Derivatives

Criterion	Criteria
Phenomenon	Phenomena
Stigma	Stigmata

-otomy = to cut into
-ostomy = to make and *leave* an opening in
-ectomy = to cut out (remove)
Ovariotomy and tracheotomy are wrong but usage has made them acceptable.

(9) Pronunciation

o-o-phor-ect-o-my — six syllables
1 2 3 4 5 6

like zo-o-lo-gy- you would not say zoo-lo-gy, so don't say oo-phorectomy
how do you pronounce *coordinate?*

(10) Saphenous

"To really start a laugh in us
Just call this vein the saphenous.
Remember that its blood is *venous*
And then you'll always say saphenous."

We can't go so far as to say ēsophágeal (rhymes with "be so fragile") and that is the only pronunciation the dictionary gives—so, maybe saphenous will soon cease to cause a laugh in us.



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EDITORIALS

The September Meeting

WITH the development of Telstar by the Bell Telephone System we have seen recently the beginning of international television. This is an impressive achievement in the field of communications and Telstar and other communications satellites will be used to transmit medical information in the years ahead. Such spectacular means of communications, however, are not expected to take entirely the place of physicians meeting together as Kentucky physicians do each September.

The KSMA Program Committee, with E. D. Pellegrino, M.D., as chairman, has developed an excellent program for the meeting this September. A number of panel discussions will be presented in the General Sessions dealing in depth with such subjects as "The General Aspects of Emotional Problems," "Management of Thoracic Emergencies," "Management of Heart Disease in Pregnancy," and "Athletic Injuries."

A clinicopathological conference on "Renal Diseases" will be presented in an interesting manner. A transatlantic communication system will permit a number of well-known British physicians to participate in the case conference.

The many specialty groups have formulated interesting programs that will consider such important subjects as "Anesthesia for Obstetric Delivery," "Medical Treatment of Pulmonary Emphysema," "The Recognition of Heart Disease in Infants," "Orthopaedics in the Office or Emergency Room," "Enlarged Lymph Nodes: A Clinical Pathological Problem," and many other important subjects. A member of the KSMA may select from the program those subjects which are of particular interest to him and attend any of the specialty group meetings.

Additional opportunities for most helpful information will be found in the two exhibit areas, scientific and technical. These carefully selected and prepared exhibits will provide a wealth of practical material which can be easily absorbed at your convenience.

Associated with the September meeting there will be many pleasant informal and formal social occasions. There will be programs and social events for the wives. The meeting will not only provide an opportunity to continue one's medical education, but an opportunity to renew old friendships and to make new ones.

Walter S. Coe, M.D.

Hospitals, Government and Politics

WHILE we are directing our attention and energy towards the fight against the socialization of physicians themselves we are, I am afraid, very possibly losing our freedom to an attack from another direction. We are speaking of political and public control of our private hospitals. This control is being imposed from a number of directions and on a number of levels: County, State and Federal.

For a number of years the American Medical Association, American College of Surgeons, American College of Physicians and American Hospital Association have joined together to form the Joint Board of Accreditation which has raised the standards of many hospitals throughout the country. While many of us as individuals have been inconvenienced by and have been critical of this organization it has done a great service in helping to put our hospital care on such a high plane that it has been recognized as second to none in the world. We must remember that this is our board created by ourselves and run as a private enter-

prise. No funds are given it by any governmental body. There is no political control except by ourselves.

There is a fault in that the board does not reach the small community hospitals. Under the present high set of standards many small hospitals do not wish to or are not able to reach the level of required elaborateness for financial if for no other reason. Our board should realize that 30-50 bed hospitals can also meet a standard of excellence without meeting the same elaborate set-up that 100-300 bed hospitals maintain.

Bureaucratic controls are threatening our local hospitals by the possible eventual passage of some sort of medical care bill. The Federal Government is most certainly going to require certain standards to be met and some sort of bureaucratic system is going to be set up to make sure these standards are met. Would it not be better to set up our own standards through the Joint Board of Accreditation and suggest that the government utilize them?

A more subtle and undermining situation is becoming evident at the county level in certain communities where the fiscal court makes a political patronage plum of the hospital administration. Very few counties, if any, in this state support their hospitals on a substantial fiscal basis although many hospitals built under the Hill-Burton Act are called "county hospitals." Ninety per cent of the income for these hospitals comes from various insurance companies including Blue Cross and commercial plans plus funds from the pockets of the individual tax payers, paid for services rendered. Attempts to upgrade the standards of these small hospitals and run them properly by qualified administrators and aides are being thwarted by certain fiscal courts demanding control of the purchasing policies and of the higher salary level appointments in the hospitals.

The community hospital may be one of the largest businesses in a small town; quite comparable to a small factory. Even the smaller 30-bed Hill-Burton Hospitals spend close to half a million dollars a year in salaries and purchases. It behooves the Kentucky Hospital Association, the Kentucky State Medical Association and its individual members to keep watch on this situation of fiscal court control and to see that it does not become more prevalent; that it is corrected now in those locales where it has gotten a start. It has already been amply demonstrated in this state that hospital care will suffer if the administration and medical policy of the hospital become subject to the whims and demands of a fiscal court. Lack of permanence and continuity of policy alone are enough to make any given fiscal court unsatisfactory as a hospital governing body.

J. B. Holloway, M.D.

Immunization Season

MANY areas in Kentucky have begun their program of mass immunization against polio as urged by state and national health authorities. This time the Sabin oral vaccine is being used in three separate doses. The public response to these activities to date has been very encouraging.

Congratulations to the Pulaski County Medical Society and County Health Department, the Bullitt County Medical Society and Health Department, McCracken, Fleming and Ballard Counties, and to the Campbell-Kenton-Boone County Medical Association, the Bourbon County Medical Society and the Washington County Medical Society. All of these organizations have their plans well in hand and deserve credit for their initiative.

Most of the other communities in the State should and will get underway with their programs in the very near future.

It must be remembered that the individual physician has a responsibility to maintain a continued interest in his own clientele and make readily available to his patients this prophylaxis. There are many who will not attend the mass immunization clinic and who will forget or neglect to voluntarily consult their private physician. In this segment of population lies a great potentiality for the occurrence and spread of polio.

It is predicted that influenza A-2, the Asian strain, is due to recur in the United States in epidemic proportions during the next fall and winter. The Surgeon General of the Public

Health Service upon the recommendation of the Advisory Committee on Influenza urges early vaccination against this epidemic disease. The "susceptible population" includes the aged, the chronically ill and pregnant women and has been expanded to all persons over the age of 45 years.

Public Health authorities recommend that those not previously immunized should receive 1 cc of the polyvalent influenza vaccine as soon as practicable after September 1, the second 1 cc dose about two months later. Those previously immunized should receive 1 cc dose subcutaneously in the early fall. It is advised that the course of immunization should be completed by mid-December for the greatest possible protection.

Physicians who have used the newer forms of influenza vaccine consistently during the past three years believe that it is effective in a very high percentage of cases. It would seem to be our responsibility to the public that the advice of the Surgeon General be practiced as widely as possible.

Sam A. Overstreet, M.D.

More On King-Anderson

KING-ANDERSON H.R. 4222 was defeated in the Senate by a too narrow margin, and it will be introduced in the new Congress just as surely as January 1963 arrives. If it is defeated again, it will be right back. If it passes, more amendments will be in order and the fight will continue.

The 200 New Jersey physicians who signed a non-participation resolution were severely criticized by proponents of King-Anderson. They were threatened with reprisals by some of the New Jersey State Legislators and were said to have used poor judgment by some of our own group.

The allegiance to some sort of resolution of non-participation by a great majority of the United States physicians may be the only means of avoiding socialization. Our British colleagues who are in the United States say that we do not have to have it if we do not want it, meaning that if enough physicians refuse to participate, no such program can possibly succeed. Non-participation does not necessarily mean the refusal to treat patients.

The New Jersey physicians may be on the right track. It is worthy of thought and if a large majority of us were of the same opinion, and would act accordingly, the politicians would have to promise something else in order to be elected. Then the unending fight against social legislation concerning medical care would cease.

If we are not willing to be resolute in what we believe to be right, we must then accept some of the blame ourselves for what is certain to follow. Let it not be truthfully said that organized medicine was guilty of negligence in allowing malignant degeneration to take place in our time-honored profession.

Delmas M. Clardy, M.D.





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SEARLE

Research in the Service of Medicine



Charles Alexander Vance, M. D.

1880-1962

CHARLES ALEXANDER VANCE, M.D.
1880-1962

CHARLES Alexander Vance, M.D., Lexington, president of the Kentucky State Medical Association in 1948-49, died at the Veterans Hospital, Lexington, August 2, after a long illness. He was 82.

Doctor Vance served as a member of the House of Delegates for 15 years and was elected councilor from the 10th District in 1925. He was elected chairman of the Council (now known as the Board of Trustees) in 1930 and served in that capacity until 1947 when he was named president-elect of the Association.

In 1953 Doctor Vance was elected Speaker of the House of Delegates and served in that capacity until 1956. Members of the House enjoyed his good nature and his witty remarks. Serving as co-chairman of the McDowell Home Shrine Committee, Doctor Vance made many important contributions to the leadership of the committee and to the work in the restoration of the home and apothecary shop.

In 1950 Doctor Vance became the sixth KSMA member to receive the Distinguished Service Award from the Association.

Doctor Vance was the senior surgeon on the staff of the Good Samaritan Hospital, Lexington, from 1926 to 1946 and consulting surgeon in 1946. He also was the senior consulting surgeon at the Veterans Administration Hospital at Lexington. He retired from active practice in 1959.

He was a fellow of the American College of Surgeons; a member of the American Medical Association, a member and former president of the Southern Surgical Association, a member of the Association for the Surgery of Trauma, member and 1950 president of the Kentucky Surgical Society, member of the Fayette County Medical Society and of the Southern Medical Association.

During World War I, Doctor Vance served as a captain in the Medical Corps. He was the author of numerous scientific and historical papers and was for many years a member of the board of curators of Transylvania College.

Doctor Vance was born at Lexington March 23, 1880, the son of the late John T. and Emma Gibney Vance. He was graduated from Transylvania College in 1900 and from the University of Louisville School of Medicine in 1903.

He is survived by his widow, Mrs. Helen Sheldon Vance, with whom he celebrated his 50th wedding anniversary November 22, 1959, and by two sons, Henry Shelden Vance of Lexington, and Lt. Col. Charles A. Vance, Jr., Luke Air Force Base, Glendale, Ariz., and by two grandchildren.

ORGANIZATION SECTION

Transatlantic CPC on Renal Disease To Be KSMA Meet Feature

Groups of physicians in Kentucky and Scotland will have an opportunity September 19 during the Annual Meeting of the Kentucky State Medical Association to extend their knowledge of renal disease by means of a transatlantic telephone hook-up.

The Kentucky physicians will gather at Columbia Auditorium, Louisville, at 2 p.m. on that date. The British audience will be in the Faculty Hall of the Royal Faculty of Physicians and Surgeons in Glasgow where the time will be 8 p.m. The program is sponsored as a medical education service by Smith, Kline and French Laboratories, Philadelphia, and its British subsidiary.

The discussion will center on two case histories, one presented by the panel of Kentucky physicians and the other by the panel of British physicians. (See page 847.)

On the basis of the information provided by one group, including visual aids, the other will endeavor to furnish a specific diagnosis.

The discussion will be broadcast over a public address system at each location. Large photographs of the British physicians will be placed on the stage in Louisville and as each speaks a red light will go on beneath his picture. A similar arrangement with pictures of the Kentucky physicians, will be set up in Scotland.

The September 19 program will be the 11th time that Smith, Kline & French has sponsored a transatlantic telephone link medical education program.

Members of the Kentucky panel, all from the University of Kentucky College of Medicine, are: E. D. Pellegrino, M.D., professor and chairman, Department of Medicine; Harold D. Rosenbaum, M.D., professor and chairman, Department of Radiology; Wellington B. Stewart, M.D., professor and chairman, Department of Pathology; Frank Cole Spencer, M.D., professor of surgery, Department of Surgery.



Doctor Jacobs



Doctor Kennedy



Doctor Rennie



Doctor Patrick

Members of the Glasgow panel are: Arthur Henry Jacobs, F.R.C.S., F.R.F.P.S., consultant, Royal Infirmary, Glasgow; Arthur Kennedy, M.D., lecturer at Glasgow University, consultant at the Royal Infirmary; Robert S. Patrick, M.D., D. P. H., senior lecturer in pathology, University of Glasgow; assistant pathologist, Glasgow Royal Infirmary; John Basil Rennie, M.D., F.R.C.P., F.R.F.P.S., lecturer, clinical medicine, University of Glasgow.

Doctors Halsted and Allen Will Be KSMA Meeting Speakers

James A. Halsted, M.D., Detroit, Michigan, will address the first scientific session at the Annual Meeting of the Kentucky State Medical Association, Tuesday morning, September 18, on "Some Important Health Problems in Underdeveloped Countries."

Doctor Halsted is chief of the Department of Medicine at Metropolitan Hospital in Detroit and associate clinical professor of medicine at Wayne State University College of Medicine. In 1958 he went to Iran as Fulbright visiting professor of medicine at the University of Shiraz and was reappointed Fulbright professor in 1959 and made chief of the medical service

To Discuss Canadian Problems

D. W. Penner, M.D., Winnipeg, Manitoba, Canada, has accepted an invitation to address the House of Delegates of the Kentucky State Medical Association at its dinner meeting, September 17 at 6:30 p.m. prior to the annual meeting of the Association, September 18-20.

Doctor Penner is American Society of Clinical Pathologists councilor from Canada. On page 870 of this issue is a Special Article by Doctor Penner on "Medical and Hospital Care Programs in Canada—1962," which is reprinted from the monthly bulletin of the American Society of Clinical Pathologists.

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1. Ford, R. A., and Blanchard, K: Journal-Lancet 78:185, 1958.

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Doctor Halsted



Doctor Allen

at the Nemazee Hospital and chairman of the department of medicine at the Shiraz Medical School.

Upon returning from Iran, he was for a time assistant to the president at the University of Kentucky Medical Center at Lexington.

Henry F. Allen, M.D., Boston, Mass., will address the session of the Kentucky Eye, Ear, Nose & Throat Society, Thursday afternoon, September 20. His subject will be: "Staphylococcus Aureus vs. Pseudomonas Aeruginosa: A Study in Contrasts."

Doctor Allen is associate surgeon in ophthalmology at the Massachusetts Eye and Ear Infirmary; assistant clinical professor of ophthalmology at the Harvard Medical School. He is secretary of the section on ophthalmology of the American Medical Association and assistant chief editor of the Archives of Ophthalmology.

Special Emergency Phone Numbers Listed for Annual Meeting

So that you may be readily reached in case of emergency while you are attending the Annual Meeting four special telephones have been set up to receive incoming calls.

The number to call at the Columbia Auditorium where all the scientific sessions are being held is **JUniper 3-1933.**

If you are attending specialty group meetings at the First Christian Church on Tuesday afternoon, September 18 or Thursday afternoon, September 20, the number to call is **JUniper 4-6377 or JUniper 4-6378.**

Members of the House of Delegates may be reached in the Roof Garden of the Brown Hotel by calling **JUniper 4-1311 Roof Garden Kitchen extension.**

Athletic Injury Conf. A Success

The Fourth Annual Athletic Injury Prevention conference on August 11 was regarded as the best attended since the conferences were first instituted under the sponsorship of the KSMA, in cooperation with the Kentucky High School Athletic Assn.

Participants were reported as very well pleased with the conference. Among observers commenting favorably was Ted Sanford, commissioner of the Kentucky High School Athletic Association.

Emergency Hospital on Display at '62 KSMA Meeting

A mobile 200-bed civil defense emergency hospital and a medical self-training kit will be demonstrated at the KSMA Annual Meeting on September 18, 19, and 20, according to William T. Rumage, Jr., M.D., Louisville, chairman of the KSMA Committee on Emergency Medical Services.

The mobile hospital and training kit will also be demonstrated at the Kentucky State Fair from Sept. 7-15.

Arrangements for the demonstration have been made through the cooperative efforts of the KSMA Committee on Emergency Medical Services, the State Department of Health, the Jefferson County Medical Society Civil Defense Committee, the Jefferson County Health Department, the civil defense office of Louisville and Jefferson County and the University of Louisville Medical Education for National Defense program.

12th Diabetes Detection Drive Planned For Nov. 11-17

The 12th Annual Diabetes Detection and Education Drive has been set for the week of November 11-17. Begun in 1951, the drive is sponsored by the KSMA in cooperation with the American Diabetes Association which has released the following checklist for the instruction of patients.

1. **Diet**
2. **Urine testing**
3. **Action of insulin and other hypoglycemic agents**
4. **Technique of insulin injection and sites for it**
5. **Care of syringe and of insulin**
6. **Symptoms of hypoglycemia**
7. **Symptoms of uncontrolled diabetes**
8. **Care of the feet**
9. **What to do in case of acute complications.**

Robert S. Tillett, M.D., chairman of the KSMA Diabetes Committee urges all doctors to follow the nine-point guide and to check urine samples free for the week of the drive. Last year approximately 55,000 free tests were made and 674 positive cases were reported. Of these, 240 were previously unknown diabetics.

Members of the KSMA Diabetes Committee besides Doctor Tillett are: Lewis Dickinson, M.D., Glasgow; Esten Kimbel, M.D., Frankfort; Frank Moore, M.D., Bowling Green and Cordell Williams, M.D., Hazard. The Committee has asked each of the KSMA component county societies to name Diabetes Committees for local implementation of the drive.

Research Scholarship Awarded

The Allergy Foundation of America has awarded a $600 student scholarship to James A. McCool, Burkesville, for research and clinical training in the field of allergic diseases. Mr. McCool has completed his second year at the Bowman Gray School of Medicine.

Diabetes Assoc. Holds First Annual Meeting Sept. 17

The first annual meeting of the Kentucky Diabetes Association will be held at noon on September 17 at the Brown Hotel, Louisville. A subscription luncheon will be included.

Robert S. Tillett, M.D., president of the Kentucky Diabetes Association, who announced the meeting, said that it will be open to both physicians and lay people. It is not necessary to be a member of the group in order to attend.

Guest speaker for the meeting will be L. O. Underdahl, M.D., Rochester, Minn., whose topic will be, "How I Handle Diabetes." Doctor Underdahl is consultant in medicine at the Mayo Clinic and associate professor of clinical medicine, Mayo Foundation, Graduate School, University of Minnesota.

6 Athletic Injuries Conferences Scheduled for Sept.-Oct.

Six regional Athletic Injury Prevention Conferences are scheduled to be held on consecutive Saturdays starting September 8 and continuing through October 13 under the sponsorship of the KSMA Committee on School Health in cooperation with the Kentucky High School Athletic Association.

Richard E. Davis, M.D., Central City, chairman of the KSMA School Health committee has organized a team of physicians to participate in the conferences. At press time plans also called for a dentist to participate to discuss the use of mouth guards.

Doctor Davis extended an invitation to all physicians to attend their local regional conference and called it a conference of particular importance to physicians interested in athletic injuries.

Physicians who will participate and their subjects are: Doctor Davis, "Medical Aspects of Sports"; O. B. Murphy, M.D., Lexington, "Orthopedic Problems in Sports"; and George Gumbert, M.D., "Lower Extremity Injuries."

The arrangements for the six regional conferences were handled by Ted Sanford, commissioner of the KHSAA.

Following is a list of conferences, including dates and the person in charge of making the local arrangements.

Date	Place	Person in Charge
September 8	U of K Center, Cumberland	Asst. Supt. Cecil A. Thornton, Harlan Co. Schools, Harlan
September 15	Western Ky. State College, Bowling Green	Coach Jimmie Feix WKSC, Bowling Green
September 22	University of Louisville, Louisville	Athletic Director Peck Hickman U of L, Louisville
September 29	Morehead State College, Morehead	Athletic Director Bob Laughlin, MSC, Morehead
October 6	Murray State College, Murray	Dr. Chad L. Stewart, Physical Ed. Dept., Murray State College, Murray
October 13	Eastern Kentucky State College, Richmond	Athletic Director Charles Hughes, EKSC, Richmond

Board of Trustees Elects Journal Editors

Sam A. Overstreet, M.D., Louisville, was elected to his third consecutive two-year term as editor of The Journal of the KSMA by the Board of Trustees at its July 26 meeting.



Doctor Coe

At the same meeting, Walter S. Coe, M.D., Louisville, was elected associate editor, succeeding George W. Pedigo, M.D., Louisville, who resigned after serving two terms in that capacity.

Both the Board of Trustees and Doctor Overstreet expressed their pleasure at Doctor Coe's willingness to serve and their thanks to Doctor Pedigo for his many contributions to Journal progress.

A graduate of the University of Louisville School of Medicine in 1943, Doctor Coe served for several years as Book Review Editor of the Journal. An internist, he is president of the Louisville Heart Association and chairman of the KSMA Committee on Postgraduate Medical Education. He is an associate professor of medicine at the University of Louisville School of Medicine.

Doctor Simpson Addresses Druggists

Gaithel L. Simpson, M.D., Greenville, Ky., president of the Kentucky State Medical Association, July 23, told the 85th annual meeting of the Kentucky Pharmaceutical Association at Paducah that druggists should become more active in government and politics.

Doctor Simpson urged his listeners as professional men and citizens to take time from their daily lives to be active in government, to interest their neighbors and employees in their right to vote and to keep in touch with their Congressmen. Doctor Simpson said he is opposed to any compulsory program in our democracy and leveled his criticism particularly at any government-sponsored medicare program.



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Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

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Robert Cox Joins KSMA Staff As Executive Assistant

Robert G. Cox, a graduate of Western State College in 1955 with an A. B. degree, joined the KSMA staff as executive assistant on August 20. Mr. Cox was originally hired in that capacity in 1961, but was called up for active duty with the 100th division at Fort Chaffee, Ark.



Mr. Cox

A former executive vice president of the Kentucky Junior Chamber of Commerce, his previous experience also includes work at the General Electric Plant in Owensboro and as a representative of the Kentucky Division, U. S. Brewers Association, Inc.

He is a former member of the Board of Directors, Kentucky Chamber of Commerce and Advertising Club of Louisville. Mr. Cox is a member of the Organization Executives Council and the Reserve Officers Association of the U. S. and is a former member of the executive committee of the Kentucky Council on Education.



Mr. Bennett

Mr. Cox succeeds Tevis Bennett, who served as executive assistant while he was on duty with the 100th Division. Mr. Bennett had served in that capacity since September of 1961. He is presently associated with the Kentucky Farm Bureau as editor of its monthly publication.

The executive assistant's duties include close cooperation with the executive secretary in the administrative details of Associational activity and work with various KSMA councils and committees.

Cancer Conference Scheduled

The ninth annual Southeast Missouri Cancer Conference has been scheduled for Sunday, October 7 at Cape Girardeau, with all sessions to be held at the Colonial Tavern Restaurant. The conference will begin at 12:30, and invitations are being issued to physicians in southern Illinois, western Kentucky, northern Arkansas, northwestern Tennessee, and southeastern Missouri. Sponsors are the American Cancer Society, the Missouri State Medical Association, the American Academy of General Practice, and the Cape Girardeau County Medical Society.

Guest speakers at the conference will include: William T. Newton, M.D., Washington University School of Medicine; Paul J. Murison, M.D., Tulane University School of Medicine; Edward T. Krementz, M.D., also of Tulane; and Gerald O. McDonald, M.D., University of Illinois College of Medicine.

Commission on Drug Safety Set Up by PMA

Thirteen medical scientists have been appointed to the Commission on Drug Safety set up by the Pharmaceutical Manufacturers Association on July 28, according to an announcement by Commission Chairman Lowell T. Coggeshall, M.D., Chicago.

The appointments represent a responsible cross section of members from medicine, government, and the drug industry. The Commission was established in July to "advance scientific knowledge of the predictability of action in human beings of new pharmaceuticals."

Following are the new commission members: Paul R. Cannon, M.D., Chicago; Thomas Francis, Jr., M.D.; Philip S. Hench, M.D.; Hugh H. Hussey, Jr., M.D., Washington, D. C.; Chester S. Keefer, M.D., Boston; Theodore G. Klumpp, M.D., New York City; John T. Litchfield, M.D., Pearl River, N.Y.; Maurice R. Nance, M.D., Philadelphia; Leonard A. Scheele, M.D., Morris Plains, N.J.; Dr. Leon H. Schmidt, Cincinnati; Austin Smith, M.D., Washington, D.C., president of the PMA; Thomas B. Turner M.D., Baltimore; and Josef Warkany, M.D., Cincinnati.

Doctor Annis, AMA President-Elect To Address Blue Shield Meet

Edward R. Annis, M.D., president-elect of the American Medical Association, will be a featured speaker at the third annual program conference of Blue Shield Plans October 8-10 at Miami Beach, Fla. Doctor Annis will discuss "The Challenge to Medicine Today."

The theme of the conference, sponsored by the National Association of Blue Shield Plans, is "Achieving Improved Performance."

Durward G. Hall, M.D., member of the House of Representatives from Missouri's Seventh District, will discuss "Meeting the Nation's Health Care Needs"; Norman A. Welch, M.D., speaker of the AMA House of Delegates, will have as his subject, "Preserving the Traditions of Private Medical Care."

Donald Stubbs, M.D., one of three recipients of the 1960 "Health-USA" award sponsored by the metropolitan Washington, D. C., Board of Health and the Medical Society of the District of Columbia, will speak on "The Mission of Blue Shield in Serving the Public and the Medical Profession."

Doctor Morse Addresses Society

Carlisle Morse, M.D., Louisville, Ky., addressed the monthly meeting of the Lay Diabetic Society, Louisville, July 19, on "Highlights of the Meeting of the American Diabetes Association" at Chicago. Doctor Morse is counselor on the board of the latter group.

Surgeons' College to Meet

The International College of Surgeons will hold its midwest regional meeting at the Hotel Savery, Des Moines, Iowa, October 31-November 1, 1962.

Kennedy Names Doctor Willard To Head U. S. Committee

William R. Willard, M.D., Lexington, Ky., dean of the University of Kentucky Medical Center, August 16 was named by President Kennedy as chairman of a 12-member Health Resources Advisory Committee.



Doctor Willard

The committee was named by the President to aid in emergency planning for allocation of national health resources and preparedness assignments of federal agencies.

The committee met August 23-24 in Washington to discuss problems of mobilization of health resources.

Doctor Willard is a member of the American Medical Association Council on Medical Education and Hospitals and the Council on Medical Education and Hospitals of the Kentucky State Medical Association. He is also a trustee on the Rural Kentucky Medical Scholarship Fund.

Program Released By Lexington Clinic For Fall Conference

The program for the Seventh Annual Fall Clinical Conference has been released by the co-sponsors, the Lexington Clinic and the Kentucky Academy of General Practice. Set for October 11, registration will begin at 9 a.m. The program follows:

9:30 a.m.—Symposium on Trauma

Francis M. Massie, M.D., Moderator

The Injured Eye .....J. L. Stambaugh, M.D.
Subdural Hematoma .....P. H. Jones, M.D.
The Monagement of Acute Hand Injuries .....Harold E. Kleinert, M.D.
Vascular Injuries .....Richard D. Floyd, M.D.
Film: Surgical Management of Penetrating Wounds of the Abdomen in Civilian Practice ..W. A. Altemeier, M.D.
Emergency Treatment of Trauma of the Chest .....J. B. Holloway, M.D.
Trauma to the Genito-urinary Tract ....J. R. Cole, M.D.

12:15 p.m.—Luncheon and Roundtable Discussion on Trauma

2:00 p.m.—Symposium on Staphylococcal Infections

Carl H. Fortune, M.D., Moderator

The Role of the Bacteriology Laboratory in the Diagnosis and Therapy of Staphylococcal Infections .....Albert Balows, Ph.D.
The Choice of Antibiotics in Staphylococcal Infections .....W. E. Herrell, M.D.
Postoperative Staphylococcal Wound Infections and their Significance .....W. A. Altemeier, M.D.
Staphylococcal Pneumonia in Infancy .....John L. Chamberlain, M.D.
Staphylococcal Infections of the Central Nervous System in Children .....Frederick A. Horner, M.D.
Staphylococcal Enteritis .....D. H. Johnston, M.D.
Recent Concepts in the Treatment of Staphylococcal Osteomyelitis .....E. Q. Parr, M.D.

4:30 p.m.—Discussion

The program has been submitted to the AAGP for six hours of Category I Credit.

Third Medical Class to Enter U. of K. In September 1962

The University of Kentucky College of Medicine, Lexington, will admit its third class of students in September 1962.

It will be composed of 70 men and four women bringing the total number of students to date to 174. There are 40 students in the class of 1964; 60 in the class of 1965.

The new class, 1966, draws 73% of its members including three of the women from Kentucky. They represent 32 of Kentucky's counties. The non-residents are from 11 other states. Of the 74 members, 67 have earned college degrees including one master's degree. They did their undergraduate work at 12 diffferent Kentucky colleges and universities and 31 out-of-state-schools.

The College of Nursing will also admit its third class and the College of Dentistry will admit its first group of students.

U. of L. Names Marshall

William H. Marshall, M.D., has been named Price fellow in surgical research and instructor in surgery by the University of Louisville School of Medicine Department of Surgery.



Doctor Marshall

Doctor Marshall received his M.D. degree from the University of Illinois. He served as lieutenant, senior grade, in the U.S. Navy from 1955 to 1957. From 1957-1961 Doctor Marshall served a four-year residency in surgery under Warren H. Cole, M.D., at the Illinois Research and Education Hospital and following this has held a position as instructor in surgery under Doctor Cole.

KSMA Lists New Members

The following are new members of the Kentucky State Medical Association:

William A. Johnson, M.D., Frankfort
Thomas H. Baker, M.D., Frankfort
John I. Cooper, M.D., Bedford
Jere Calvin Robertson, M.D., Hopkinsville
Wylda Hammond, M.D., Lexington
R. W. O'Gorman, M.D., Lexington
Cecil L. Grumbles, M.D., Louisville
Morris Weiss, Jr., M.D., Louisville
Edward Haick, M.D., Louisville
William H. Marshall, M.D., Louisville
Gerald Landau, M.D., Louisville
Jay S. Koby, M.D., Louisville

Kentucky-Cornell Auto Injury Research Is Begun

On August 1, physicians in the following counties in Kentucky began participation in the automobile-crash injury studies sponsored by Cornell University: Anderson, Bell, Fayette, Franklin, Knox, Harlan, Scott, Shelby, Spencer, and Woodford. Physicians will be asked to provide medical information during the six-month period ending January 31, 1963, in which their county is represented in the sampling area. There will be six areas and six reporting periods causing the entire Kentucky study to last three years.

Kentucky organizations which have formally agreed to cooperate with studies are the Department of Safety, Department of Health, Kentucky Hospital Association and the KSMA. Kentucky is the 24th state in which these groups have agreed to work with the study.

Information derived from injuries sustained in accidents involving passenger cars and investigated by the State Police has been used in designing passenger protection devices in automobiles. The Kentucky study will help evaluate the effectiveness of safety mechanisms already adopted as well as showing the need for additional protections.

Three Seminars Held In August By KAGP

The Kentucky Academy of General Practice held three seminars in various locations during August. The Annual London Seminar was held at Sue Bennett College, London, on August 1 with the following guest speakers: Carl H. Scott, M.D.; George Gumbert, M.D.; O. B. Murphy, M.D., and Wallace E. Herrell, M.D., all of Lexington; Robert J. Brimi, M.D., Knoxville, Tenn.; and G. David McClure, M.D., Louisville. Paul R. Smith, M.D., London, was seminar chairman.

On August 19 the Bluegrass Seminar was held at the University of Kentucky Medical Center, Lexington, with Harold C. Haynes, Jr., M.D., as chairman and Arnold C. Williams, M.D., as moderator. Both are from Lexington. Guest speakers on the program included: Lawrence B. Goldberg, M.D., Cincinnati; James Warren, M.D., Columbus, Ohio; Clinton R. Potts, M.D., and William C. Mitchell, M.D., both of Louisville.

Park City was the site of the Cave Area Seminar on August 23. John C. Ayers, Jr., M.D., Cave City, was chairman and the following were participants in the program: William W. Winternitz, M.D., Lexington; A. B. Loveman, M.D., Louisville; S. T. Bill-



Participating in a press conference on the Cornell Crash Research Program in Louisville on July 18 were—Front Row—Col. David A. Espie, director of State Police; Russell E. Teague, M.D., State Commissioner of Health; Arthur H. Keeney, M.D., Louisville, chairman, KSMA Highway Safety Committee. Back Row—Louis G. Schweizer, Jr., Louisville Police Department; W. Leon Hisle, Berea, Kentucky Hospital Association; Russell Jewett, Frankfort, member of the legislative research committee; and Victor Fuqua, Director of the Division of Accident Prevention, State Department of Health.



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ings, M.D., Nashville, Tenn.; E. D. Pellegrino, M.D., Lexington, and Mr. Elwood Rowsey, Park City. Each of the three programs had been submitted for five hours of Category I Credit by the AAGP.

In addition, the KAGP held its Kenlake Seminar in Gilbertsville on July 19 with George C. McClain, M.D., chairman, and Joseph R. Miller, M.D., as co-chairman. F. Albert Olash, M.D., and Lonnie W. Howerton, M.D., Louisville; Jack Githens, M.D., and Harvey Chenault, M.D., Lexington, were guest speakers. The program for this seminar was also submitted for five hours of Category I Credit.

Diagnosis of Chest Diseases To Be Postgraduate Course Theme

The Department of Radiology of the University of Kentucky Medical Center will offer a postgraduate course in "X-Ray Diagnosis of Chest Diseases" beginning at 7:30 p.m., Thursday evening, October 18, at the Center. The course will be continued for five successive Thursday evenings.

The schedule for the five evenings is as follows: October 18, "Pneumonia," Z. S. Gierlach, M.D.; October 25, "Pleural and Mediastinal Disease," Daniel J. Hanson, M.D.; November 1, "Pulmonary Neoplasms," Arthur Lieber, M.D.; November 8, "Pulmonary Emphysema, Fibrosis and Pneumoconiosis," Harold D. Rosenbaum, M.D.; November 15, "Pulmonary Congestion and Infarction," Arthur Lieber, M.D.

Each session will consist of an hour of formal presentation plus an additional 30 minutes of questions and answers.

Postgraduate Pediatric Course Scheduled At U. of K.

The first annual postgraduate course conducted by the Department of Pediatrics of the University of Kentucky Medical Center with the aid of the KSMA Office of Postgraduate Medical Education will be held October 5 and 6 at Lexington. "The Early Origins of Disease in Children and Their Implications in Management" will be the theme of the course and Warren E. Wheeler, M.D., Editor of the American Journal of Diseases of Children will be the principal speaker.

Subjects and speakers on the program include the following:

Chromosomes and Genes in Disease . . John H. Githens, M.D.; James Rackley, M.D.; C. Charlton Mabry, M.D.; Richard S. Schweet, Ph.D.

Genetic Traits of Bacteria and their Effects on Virulence and Epidemiology . . . . . Warren E. Wheeler, M.D.

Newer Diagnostic Techniques in Genetically Determined Diseases: Discussion and Demonstrations . . members of the Pediatric Staff

Hereditary Disease in the Newborn Nursery . . . . . John Boehm, M.D.

Hereditary Hemorrhagic Defects . . . . William Hathaway, M.D.

Serum Proteins and Their Role in Disease . . . . . Thomas L. Nelson, M.D.

Prospectives and Thoughts . . . Warren E. Wheeler, M.D.

Anesthesiology Course Set For Oct. 3

A postgraduate course in anesthesiology with special emphasis for the general practitioner is scheduled for October 3 in the surgical conference room at Louisville General Hospital. Sponsored by the Section on Anesthesiology of the University of Louisville School of Medicine, the course is part of a coordinated program of continuing education sponsored by the U. of L., the University of Kentucky College of Medicine, the Kentucky Academy of General Practice and the Office of Postgraduate Medical Education of the Kentucky State Medical Association.

Guest speakers on the program will be Robert Dodd, M.D., professor of anesthesiology, Washington University Medical School, St. Louis, Mo., and J. H. Marcy, Jr., M.D., chief of anesthesiology at Children's Hospital, Pittsburgh, Penn.

Topics to be discussed will be:

I. Management of Patients Who Have Sustained Multiple Injuries

A. Diagnosis, Resuscitation and Safeguards in the Patient With Multiple Injuries: Surgical Considerations . . Herbert T. Ransdell, Jr., M.D.

B. Anesthetic Management of the Patient With Multiple Injuries . . . . . Donald M. Thomas, M.D.

II. Anesthesia for the Pediatric Patient

A. Techniques and Equipment for Use in Pediatric Anesthesia . . . . . M. M. Saint Pierre, M.D.

B. Certain Aspects of the Physiology of Infants and Children of Interest to the Anesthesiologist . . J. H. Marcy, Jr., M.D.

C. Panel Discussion: Problems in Pediatric Anesthesia . . . . Thomas N. MacKrell, M.D., Moderator; J. H. Marcy, M.D.; M. M. Saint Pierre, M. D.; Robert Dodd, M.D.

III. The Place of Ether in Anesthetic Practice Today

A. Ether in Historical Perspective . . Eugene H. Conner, M.D.

B. Uptake and Distribution of Diethyl Ether . . Thomas N. MacKrell, M.D.

C. Pharmacology of Diethyl Ether . . . Robert Dodd, M.D.

Panel Discussion: Has Ether Been Replaced by Other Agents? . . . . Eugene H. Conner, M.D., Moderator; Robert Dodd, M.D.; Thomas N. MacKrell, M.D.; Robert P. Bergner, M.D.; Chester B. Theiss, Jr., M.D.

The course has been submitted to the American Academy of General Practice for Category I Credit approval.

Doctor DeVoe To Speak

Arthur Gerard DeVoe, M.D., New York City, will be the guest speaker at the section of ophthalmology of the Southern Medical Association at the annual meeting at Miami Beach, the week following the Association's annual meeting November 12-15.

The 1962 Mississippi Valley Thoracic Society will meet October 12 at the Claypool Hotel, Indianapolis, in conjunction with the Mississippi Valley Conference on tuberculosis.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

New Service Offered by KSMA Postgraduate Office

An up-to-date listing of professional teaching films will be made available to Kentucky State Medical Association members by the Postgraduate Office, beginning September 10.

These films, provided by pharmaceutical houses, cover almost every field of medicine. Many of them are in color. They are available on a loan basis and information about them, including synopses, running time and booking data is now available through the PG Office, 3532 Janet Avenue, Louisville 5, Ky.

A list of the films will be supplied to anyone requesting this information and the PG Office will also handle ordering and delivering the film unless the group wishes to do so independently.

The Postgraduate Office will be happy to provide this service, demonstrating one more way in which the Postgraduate Office can be of real help to KSMA members.

In Kentucky

SEPTEMBER

18-20	KSMA Annual Meeting, Columbia Auditorium, Louisville, Kentucky.

OCTOBER

3	Postgraduate Course, "ANESTHESIOLOGY—SPECIAL EMPHASIS FOR GENERAL PRACTITIONERS," Louisville General Hospital, Louisville, Kentucky.
4	KAGP Seminar, Henry Clay Hotel, Ashland, Kentucky.
5	Monthly Postgraduate course—Pediatrics, University of Kentucky Medical Center, 1-4 p.m. This course will continue to be held the first Friday of each month.
5-6	Postgraduate Course, "THE EARLY ORIGINS OF DISEASE IN CHILDREN AND THEIR IMPLICATIONS AND MANAGEMENT," University of Kentucky Medical Center, Lexington, Kentucky.
10	Lexington Clinic, Lexington, Kentucky.
10, 17, 24, 31	Jefferson County Chapter Academy of General Practice, Fall Seminar, Louisville, Kentucky.
11	"Mammography," J. Gershon-Cohen, M. D., 7:30 p.m., University of Kentucky Medical Center, Lexington, Kentucky.
18	KAGP Seminar, Maysville, Kentucky.
18-25	"X-Ray Diagnosis of Chest Diseases,"
Nov. 1-8-15	7:30 p.m. University of Kentucky Medical Center, Lexington, Ky.
25	Kentucky Rural Health Conference, Cumberland Falls, Kentucky.

NOVEMBER

7-14-21-28	"Electrocardiogram Interpretation," 7 to 8:00 p.m., Thursday evenings, Louisville General Hospital, Louisville, Ky.
8-10	KAGP Interim Meeting, Phoenix Hotel, Lexington, Ky.

Surrounding States

SEPTEMBER

19-21	Postgraduate Course, "Basic Electrocardiography," Indiana University, Indianapolis, Indiana.
21-22	"Diagnosis and Treatment of Gastrointestinal Diseases," Ohio State University, Columbus, Ohio.
24 thru Oct. 6	PG Course in Laryngology and Bronchoesophygology, Univ. Illinois, College of Medicine, 1853 W. Polk St., Chicago 12.

Cook County Graduate School of Medicine, Chicago, Ill., has various courses during September, information on request.

OCTOBER

1-4	Interstate Postgraduate Medical Association of North America, Palmer House, Chicago, Illinois.
12	Mississippi Valley Thoracic Society with the Mississippi Valley Conference on Tuberculosis, Claypool Hotel, Indianapolis, Indiana.
15-19	American College of Surgeons, Atlantic City, New Jersey.
22-23	American Cancer Society Annual Session, New York, New York.
26-28	American Heart Association Annual Meeting, Cleveland, Ohio.
28-31	American College of Gastroenterology, Morrison Hotel, Chicago, Illinois.
29-November 1	American Academy of Pediatrics Annual Meeting, Chicago, Illinois.

Cook County Graduate School of Medicine, Chicago, Ill., has various courses during October, information on request.

NOVEMBER

8-10	American College of Obstetricians and Gynecologists, District 5, Indianapolis, Indiana.
12-15	Southern Medical Association, Miami Beach, Florida.
25-28	AMA Clinical Meeting, Los Angeles, California.

$96,106 In Grants Allocated By Ky. Heart Assoc.

Grants totaling $62,550 have been allocated by the Kentucky Heart Association to finance basic-research programs. Another $33,556 will go for non-research purposes. These amounts supplement grants of $86,495 announced earlier by the American Heart Association for research projects in Kentucky.

Recipients of research grants at the University of Louisville are: Joseph P. Holt, M.D., $15,000; Maurice Best, M.D., $4,800; Ellis A. Fuller, M.D., $5,000; Marvin Murray, M.D., $3,500; J. Alex Haller, Jr., M.D., $1,795; Herbert K. Kashiwa, Ph. D., $4,550; Richard C. McPherson, M.D., $2,200; N. J. Carlisky, M.D., $1,600, and nine student-research scholarships totaling $5,400.

At the University of Kentucky, the following received research grants: Morris Scherago, M.D., $2,000; Edmund D. Pellegrino, M.D., $6,500; Alberto Mazzoleni, M.D., $5,250; Harold Rosenbaum, M.D., $1,655, and four student-research scholarships totaling $2,400.

Nonresearch grants include: Joseph A. Little, M.D., for a heart clinic at Children's Hospital, Louisville, $11,300; Leonard Leight, M.D., for a cardiac-catheterization unit at Louisville General Hospital, $7,000; Richard R. Crutcher, M.D., for a cardiac-catheterization unit and surgical facility at St. Joseph Hospital, Lexington, $10,600; purchase of books and journals for the U. of L. medical school library, $400; J. Alex Haller, Jr., M.D., for salary of medical technician at Children's Hospital, Louisville, $3,600; and Charles McGraff, M.D., for purchase of a Sanborn Heart Sounds Speaker at General Hospital, Louisville, $656.

According to Robert A. Thornbury, executive director of the Kentucky chapter, 98.8 per cent of the funds collected in Kentucky during the annual Heart Fund drive will be spent here for heart research and treatment.

Plans Are Announced for Session of American Heart Group

Six all-day programs on clinical cardiology of primary interest to practicing physicians are scheduled for the 1962 annual scientific sessions of the American Heart Association October 26-28 in the Public Auditorium at Cleveland, Ohio.

The clinical sessions will run simultaneously with the regular sessions dealing with special aspects of cardiovascular research. Each will include presentation of orginal clinical investigative work, panels, symposia and lectures.

Some of the subjects to be covered: Circulation, high blood pressure research, rheumatic fever, congenital heart disease, arteriosclerosis, cardiovascular surgery.

KSMA Council, Committee Reports

Council on Legislative Activities

John C. Quertermous, M.D., Chairman

Headquarters Office Bldg., Louisville **July 11, 1962**

A meeting of KSMA's Council on Legislative Activities was held at the Headquarters Office Building Wednesday, July 11. The primary purpose for the meeting was to have Council members review, make necessary changes and approve the reports of the chairmen of State and National Legislative Affairs. These reports will be presented to the House of Delegates at KSMA's Annual Meeting. The Council expressed satisfaction and appreciation for the large number of resolutions and letters written in opposition to the King-Anderson Bill (H. R. 4222). It felt that letters and telegrams should be directed immediately to Kentucky senators opposing the proposed amendment to the Welfare Bill (H. R. 10606), since this is the Senate approach to revive medical care for the aged under Social Security.

County Society Reports

McCracken County

A special called meeting of the McCracken County Medical Society was held at 7 p.m. August 1 in Paducah. J. Vernon Pace, M.D., president, reminded those present that only special business before the society would be discussed. He then called on Goodloe Sargent, M.D., Barlow, to discuss the proposals for a mass immunization program in this area with Sabin polio vaccine.

Following Doctor Sargent's remarks William P. Haley, M.D., Paducah, made a motion that the McCracken County Medical Society make arrangements for the procurement of Sabin vaccine and also make arrangements for the administration of the vaccine in a mass immunization program in Paducah and McCracken County. The motion was seconded and discussed and an amendment was proposed that the Society underwrite any deficit that occurs as a result of the mass immunization program. Both the amendment and the motion were passed unanimously.

It was then moved that a committee be appointed by the president to implement the motion. The motion was seconded and carried and the following committee was set up at a brief Executive Committee meeting following adjournment: Doctor Sargent and Walter R. Johnson, M.D., co-chairmen; Edwin T. Davis, M.D.; Glenn R. Noss, M.D.; Hubert R. Holland, M.D. and D. D. O'Sullivan, M.D.

Civil Defense Council Sets Meet

The 11th annual conference of the United States Civil Defense Council will be held October 15-19, 1962, at Knoxville, Tenn. Carroll P. Hungate, M.D., Kansas City, Mo., is chairman of the Health Service Advisory Committee of the Council.

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News Of The Profession In and About Kentucky

William G. Weathers, M.D., has begun the practice of general surgery at Louisville. He was graduated from Meharry Medical College, Nashville, Tenn., in 1953; served his internship at Community General Hospital, Reading, Pa., and hs residency at the Veterans Administration Hospital at Minneapolis. Doctor Weathers studied at the University of Minnesota Graduate School of Medical Sciences from 1957 to 1962 working toward a Ph.D. in surgery with a minor in pathology. He served two years in the Army Medical Corps from 1955 to 1957 with the rank of captain.

William B. Russell, M.D., has started the practice of internal medicine with the Graves-Gilbert Clinic at Bowling Green, Ky. Doctor Russell is a 1958 graduate of the University of Michigan Medical School, Ann Arbor. He served his internship at Baptist Hospital, Nashville, Tenn., and his residency in internal medicine at Veterans Hospital, Memphis, Tenn., and in pediatrics at Baptist Hospital, Nashville, Tenn.

Jere C. Robertson, M.D., has opened an office for the practice of obstetrics and gynecology at Hopkinsville, Ky. He was graduated from the University of Tennessee College of Medicine, Memphis, in 1958. He interned at St. Thomas Hospital, Nashville, Tenn. He took his residency training at Vanderbilt University Hospital and at St. Thomas Hospital, Nashville.

Donald L. Ware, M.D., has begun the practice of obstetrics and gynecology at Louisville. Doctor Ware was graduated from the School of Medicine of the University of Louisville in 1954. He interned at Louisville General Hospital. Before he took his residency training at the same hospital he practiced at Cloverport, Ky., from 1955 to 1958.

William E. Waltrip, M.D., is now associated with the Trover Clinic, Providence, Ky., in general practice. A 1960 graduate of the University of Louisville School of Medicine, Doctor Waltrip interned at the Medical College of South Carolina at Charleston and has served one year of his residency at Louisville General Hospital.

Gerald B. Reams, M.D., has begun the practice of general surgery at Ashland, Ky., in association with **J. Marvin Keeton, M.D.** Doctor Reams was graduated from Northwestern University School of Medicine, Chicago, in 1952. He interned at Charity Hospital, New Orleans, and took his residency training at the University of Miami School of Medicine. He served five years from 1957 to 1962 as a major in the United States Air Force Medical Corps.

William M. Rowlett, M.D., has begun the practice of ophthalmology in association with the Graves-Gilbert Clinic at Bowling Green, Ky. Doctor Rowlett was graduated from the University of Louisville School of Medicine in 1955; interned at the University of Oklahoma and did his residency work at the University of Tennessee.

William A. Johnson, M.D., has begun the practice of urology at Frankfort, Ky. Doctor Johnson was graduated from the University of Louisville School of Medicine in 1955. He served his internship at the University of Texas and did his residency work there also. He was in general practice at Owingsville, Ky., from 1956 to 1958 prior to taking his residency training.

David Stewart, M.D., has begun the practice of psychiatry at Louisville Ky., in association with **Theodore A. Schramm, M.D.** Following graduation from the University of Louisville School of Medicine in 1946, Doctor Stewart served his internship at Louisville General Hospital. His residency training was with the U. of L. Psychiatric Residency Program.

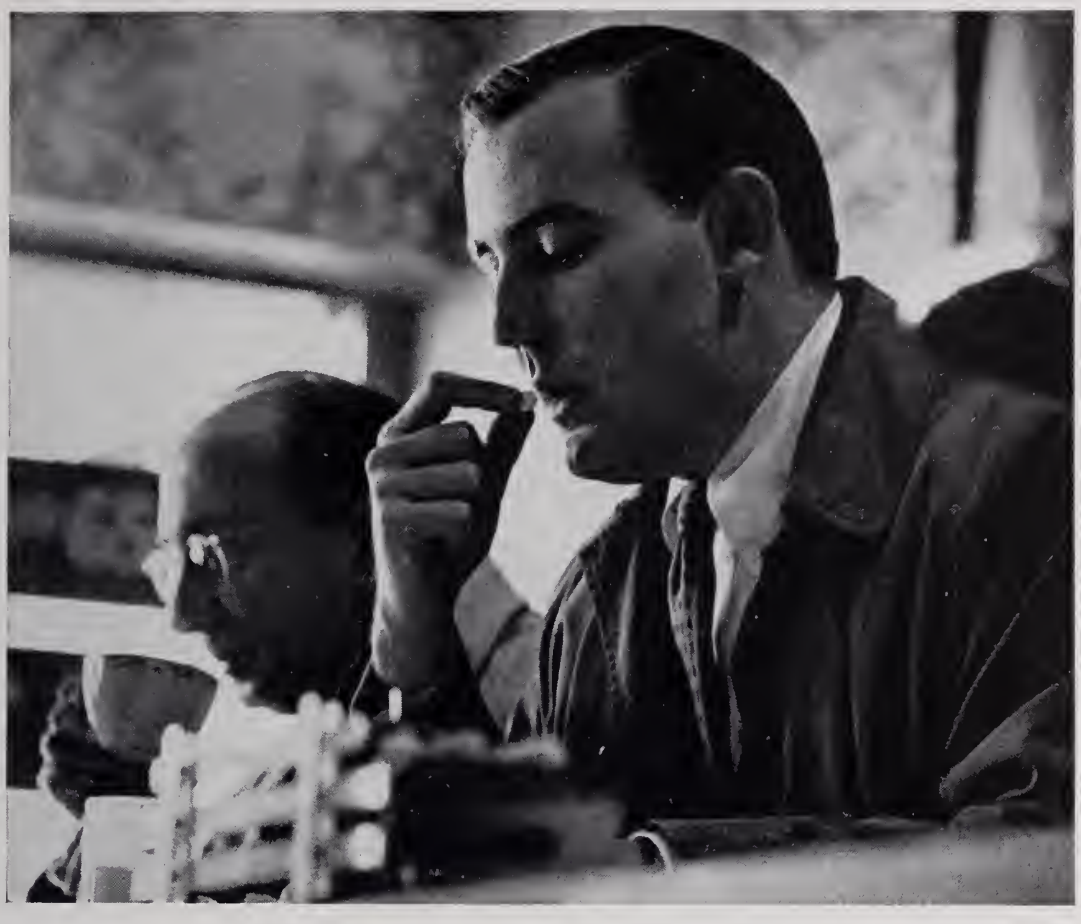
Theodore Mabini, M.D., is serving as a pathologist with Methodist Hospital at Pikeville, Ky. He was graduated from the Catholic University of the Philippines Medical School in 1952. Doctor Mabini served his internship at Lutheran Hospital, Cleveland, Ohio, in 1953 and took his residency training at Mt. Sinai Hospital. He has previously served as a lecturer in pathology and director of autopsy service at Queens University at Kingston, Ontario, Canada.

Robert Schiavone, M.D., has started general practice at Owenton, Ky., in association with **O. A. Cull, M.D.** Doctor Schiavone was graduated from the University of Louisville School of Medicine in 1961 and served his internship at Marion County General Hospital at Indianapolis.

John J. Ryan, M.D., has entered the practice of ophthalmology at Louisville, Ky. Doctor Ryan, a 1958 graduate of the University of Louisville Medical School, served a rotating internship at St. Joseph Infirmary at Louisville, after which he took a basic science course in ophthalmology at Colby College. Waterville, Me., and served as resident in ophthalmology at the Louisville General Hospital, the U. S. Veterans Hospital, Children's Hospital and St. Joseph Infirmary at Louisville.

Carmine J. Scalzitti, M.D., Louisville, Ky., has begun the practice of pediatrics in that city in association with **Elliott Podoll, M.D.** Doctor Scalzitti was graduated from the University of Louisville School of Medicine in 1956; interned and served his residency at St. Joseph Infirmary, Louisville, and served for three years in the U. S. Navy as flight surgeon.

Charles J. Bohle, M.D., has begun the practice of obstetrics and gynecology at Paducah, Ky., in association with **O. Leon Higdon, M.D.,** and **Harold D. Priddle, M.D.** Doctor Bohle received his M.D. degree from Georgetown University in 1956. He interned at St. Louis City Hospital and served his residency at St. Joseph Infirmary, Louisville, Ky. Doctor Bohle served two years in the U. S. Air Force with the rank of captain.



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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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News Notes

Robert W. Rasor, M.D., is now with the U.S. Public Health Service Hospital at Lexington, Ky., practicing psychiatry and neurology. Doctor Rasor has been with the Public Health Service since 1941 and previously was with the U.S.P.H.S. Hospitals at New Orleans and New York. He was graduated from the University of Colorado School of Medicine, Denver, in 1941 and interned at the U. S. Marine Hospital at Baltimore, Md. His residency was spent at the University of Chicago University Clinics.

John L. Chamberlain, III, M.D., has become associated with **Noble T. Macfarlane, Jr., M.D.,** Lexington, Ky., with the Lexington Clinic in the practice of pediatrics. Doctor Chamberlain was graduated from the University of Virginia Medical School in 1957. He served his internship at Mary Imogene Bassett Hospital and his residency with Vanderbilt University. He served in the U. S. Army Medical Corps from 1958 to 1960.

Donald G. Hughes, M.D., Murray, Ky., has begun general practice with the Houston-McDevitt Clinic at Murray. He was graduated from the University of Louisville School of Medicine in 1959 and served his internship at the Charity Hospital, New Orleans, La. Doctor Hughes served two years in the U. S. Air Force.

Carroll F. James, M.D., has started general practice at Hardinsburg, Ky. Doctor James was graduated from the University of Louisville School of Medicine in 1961.

Douglas R. Alvey, M.D., has begun general practice at Franklin, Ky., in association with **L. F. Beasley, M.D.** Doctor Alvey served his internship at Indianapolis General Hospital after graduation from the University of Louisville School of Medicine in 1961.

Be sure to see the outstanding collection "Medicine and Medical History on Stamps" at Stewart's September 17 through 21. This wonderful exhibit tells the story of medicine through postage stamps. Loaned through the courtesy of Dr. Joseph Kler, eminent New Jersey surgeon. Let us help you get started on a stamp collection of your own.

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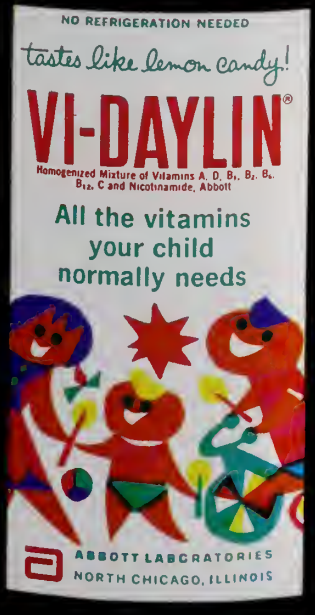
MARGARET KELLY, R. N., Director of Nurses



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VI-DAYLIN—Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide, Abbott; VIDAYLIN-M—Homogenized Mixture of Vitamins with Minerals, Abbott; VI-DAYLIN-T—High Potency Multivitamins, Abbott.



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		MDR (Children)	MDR (Infants)
Vitamin A	0.9 mg. (3000 units)	1	2
Vitamin D	10 mcg. (400 units)	1	1
Thiamine HCl (B_1)	1.5 mg.	2	6
Riboflavin (B_2)	1.2 mg.	1⅓	2
Ascorbic Acid (C)	50 mg.	2½	5
Nicotinamide	10 mg.	1⅓	2

Also supplies cyanocobalamin (B_{12}) 3 mcg. and pyridoxine Hydrochloride 1 mg.

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Gentlemen,

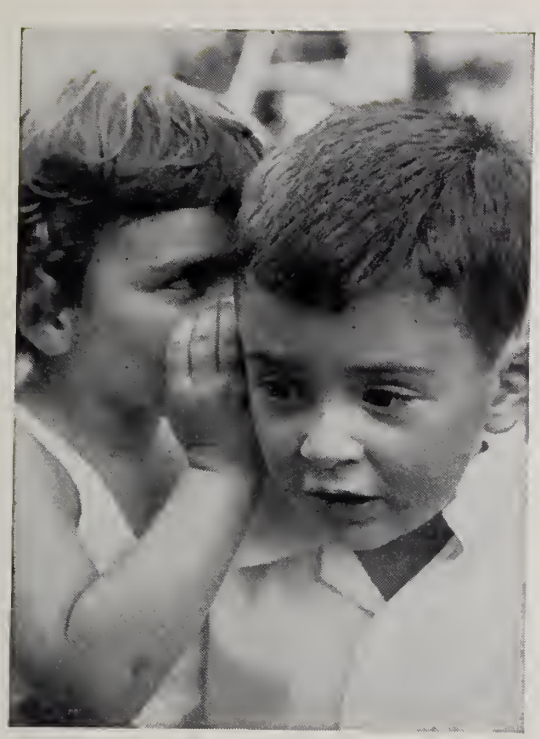
My family enjoys your chewable vitimans. It seems like we can not get enough of your vitimans. My sister enjoys your vitimans so much that she ask for more but cannot have no more. I like them because my mother does not have to worry about scolding us when taking it. Its good because you don't have no worries about something falling on the floor. If you kept on making these vitimans all the worlds children would be happy again. Now I would like to know whether I may have any information on the Middle West. You see my class and I are studying it. So if the information can be given I thank you very much.

"...all the worlds children would be happy again."

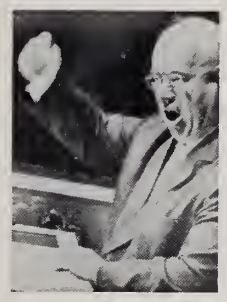
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In Memoriam

THOMAS JUETT MARSHALL
Paducah
1883-1962

Thomas Juett Marshall, M.D., 78, Paducah pediatrician, died August 7 in Western Baptist Hospital. He was the area's first pediatrician.

Doctor Marshall, a native of Ballard County, was graduated from the Hospital College of Medicine at Louisville in 1906, and started his practice as a rural doctor. Later, he studied pediatrics at St. Louis and at Columbia University. He was the first pediatrician west of Louisville to be named a fellow in the American Academy of Pediatrics and a diplomate of the American Board of Pediatrics.

JOSEPH L. BARR
Frankfort
1881-1962

Joseph L. Barr, M.D., 80, Frankfort, Ky., who had practiced medicine there for 57 years, died July 24 at St. Joseph Hospital, Lexington, after a brief illness.

Doctor Barr was a 1904 graduate of the Louisville Medical College. He was a native of Marion County and a veteran of the Spanish-American War. He began his practice at Lebanon and moved later to Frankfort where he served as prison physician and in private practice.

DICKRAN H. ERKELETIAN
Hopkinsville
1877-1962

Dickran H. Erkeletian, M.D., Hopkinsville, Ky., general practitioner, died August 2 at Jennie Stuart Hospital, where he had been a patient since he fell and broke his leg some two weeks previously.

Doctor Erkeletian had practiced medicine in Christian County for 59 years. He was born in 1877 in Erkilet, Turkey, then Armenia, and came to the United States at the age of 16 after his parents were killed in a national conflict in Armenia. He was graduated from the Medical Department of the University of Tennessee in 1903.

The American Hospital Association reports that it cost American hospitals nearly one billion dollars more to operate in 1961 than in 1960. The cost was $9,387,-242,000 in 1961, compared with $8,420,986,000 in 1960. Hospitals also cared for a record number of patients—25,474,370—an increase of nearly half a million over 1960, according to statistics which appeared in the annual Guide Issue of *Hospitals,* Journal of the American Hospital Association.

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Approved Psychiatric Residency for General Practitioners or others: First year appointment beginning July 1, 1963 in well integrated psychiatric training program associated with State University of Iowa Psychiatric Department. Requirements: Must be a citizen of United States or have expressed an intention of becoming one; have completed internship four years prior to July 1, 1963, and have been in practice during that period. Time served in Armed Forces or residency training in some other specialty acceptable. Preference given to applicants under forty-five years of age. Annual stipend $12,-000. Applications should be made immediately. Write W. C. Brinegar, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa.

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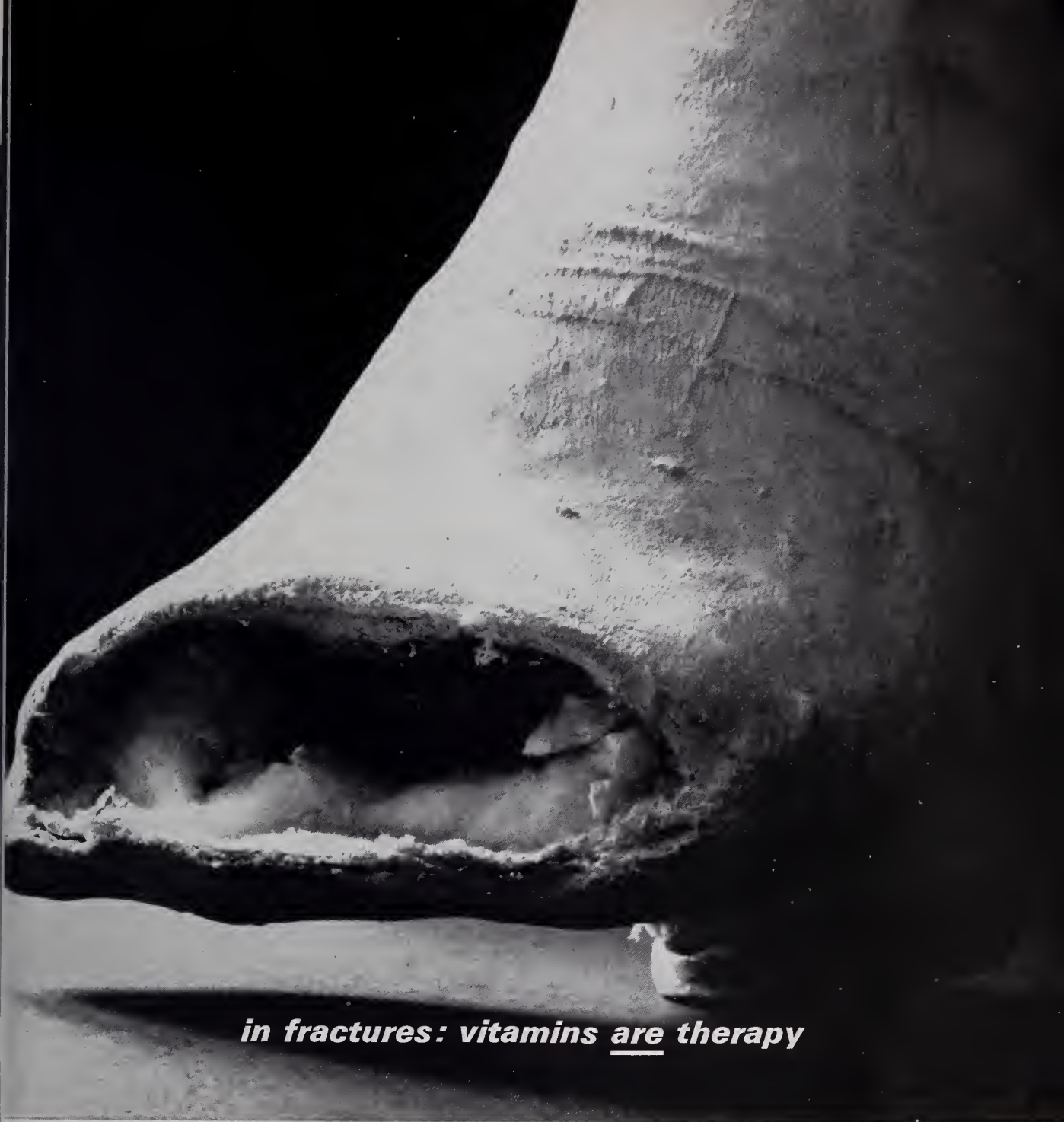
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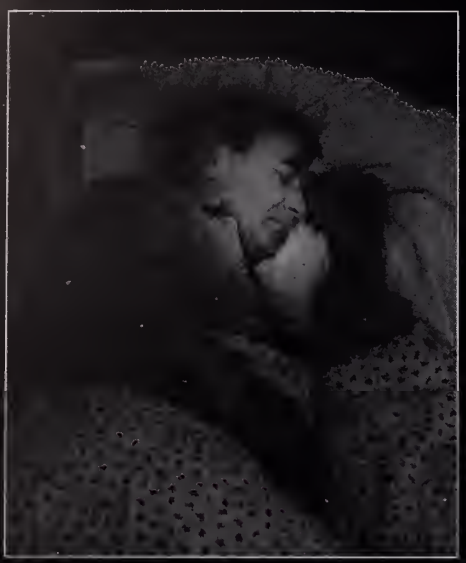
Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
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Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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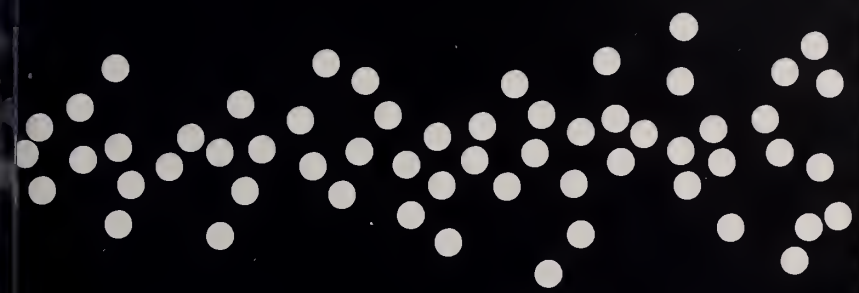
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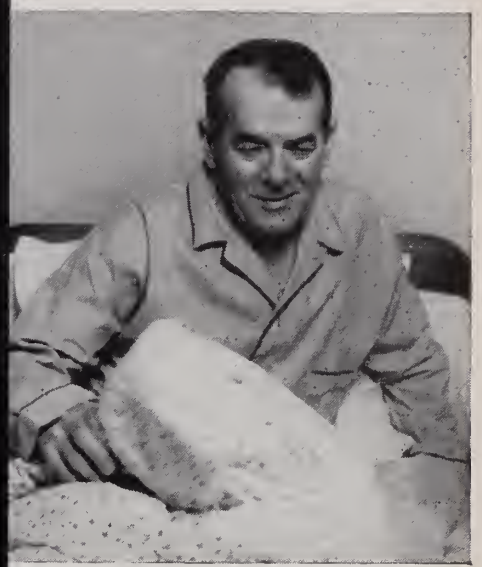


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ight, the arthritic wakes up comfortable



Morning stiffness may be reduced or even eliminated as a result of therapy with the only steroid in long-acting form. And the slow, steady release of steroid makes it possible in some cases to reduce the frequency of administration and/or the total daily steroid dosage.

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Supplied in bottles of 30 and 100.

Upjohn

The Upjohn Company, Kalamazoo, Michigan

Reminder advertisement.
Please see package insert for detailed product information.

Washington News

(Continued from Page 830)

be determined to safeguard our population."

FDA Commissioner George P. Larrick and Doctor Kelsey both agreed in testifying before the Senate Subcommittee that Merrell had acted with reasonable diligence in withdrawing thalidomide from the market. Dr. Kelsey said that if the entire matter had been up to her alone she would not have withdrawn it much sooner than the company.

Larrick also said then that the FDA had not found any infants born deformed in this country as a result of thalidomide administered in the mass clinical testing program. But he said the birth of deformed infants in this country had been reported where mothers had taken the drug after it had been procured in other nations where it had been marketed.

A Federal grand jury was investigating Merrell in connection with another of its drugs, MER-29, which was designed to inhibit formation of cholestrol in the blood.

The FDA in April, 1960, approved an application for marketing the drug. It was an instant success. But it was withdrawn in April of this year after reports that some patients taking it had developed eye cataracts, and had suffered hair loss, skin changes and leukemia.

The AMA Council on Drugs recently reported that "much longer and more careful studies" were needed to prove the safety of the drug in general or long-term use.

The FDA also investigated enovid, a birth controll pill. The FDA said there had been 28 cases reported since September in which women given the contraceptive pill developed a blood clot called thrombophlebitis. Six of them died. But the agency cautioned that fatal blood clots can be caused by many things unrelated to any drug.

The pill's manufacturer, G. D. Searle and Co. of Chicago, said a "super-charged atmosphere over thalidomide" was responsible for the FDA's investigation of enovid.

The company said a woman taking oral contraceptives runs no more risk of blood clots than a woman in normal pregnancy.

It was the second investigation ordered into the contraceptive pill since it was approved for commercial sale in May, 1960, on the basis of what the FDA called "extensive research data."

Warren P. Jurgensen, M.D., is serving as a psychiatrist with the United States Public Health Service Hospital at Lexington, Ky. Doctor Jurgensen was graduated from Creighton University School of Medicine, Omaha, Neb., in 1950 and served his internship at the Edward W. Sparrow Hospital, Lansing, Mich. He took his residency training at the U.S.P.H.S. Hospital at Lexington and at Cincinnati General Hospital. Doctor Jurgensen has spent 11 years in the U. S. Public Health Service. He most recently was with the U.S.P.H.S. Hospital at Fort Worth, Tex.

NURSING HOME FOR SALE

Fire-proof, steel-and-masonry mineral-spring sanitarium being converted into 100-bed comprehensive nursing home. Located on 2½ acre landscaped tract in Martinsville, Indiana. Ample trained help available. For drawings and details write New Highland Sanitarium Company, Martinsville, Indiana or telephone Martinsville, DIckens 2-6814, Mr. Richard Bray.

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- the most modern, coordinated, comprehensive, rehabilitative regimen
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she's losing weight

'Dexedrine' *Spansule* capsules not only control appetite all day long, but at the same time encourage normal activity. This is particularly important because overweight patients are often inactive. In such patients 'Dexedrine' overcomes lethargy, helps renew their interest in doing things—not just eating.

PRESCRIBING INFORMATION

INDICATIONS AND DOSAGE: For the following indications, the recommended daily dosage is one or two 'Dexedrine' *Spansule* capsules, usually taken in the morning: control of appetite in weight reduction; depressive states; alcoholism. In narcolepsy, the recommended daily dosage is up to 50 mg. of 'Dexedrine' by 'Spansule' capsule on arising.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Should be used with caution in patients hypersensitive to sympathomimetic compounds; in cases of coronary or cardiovascular disease; and in the presence of severe hypertension.

CONTRAINDICATIONS: Hyperexcitability; agitated pre-psychotic states.

SUPPLIED: 5 mg., 10 mg. and 15 mg., in bottles of 30. (Each capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.)

Prescribing information adopted January 1961.

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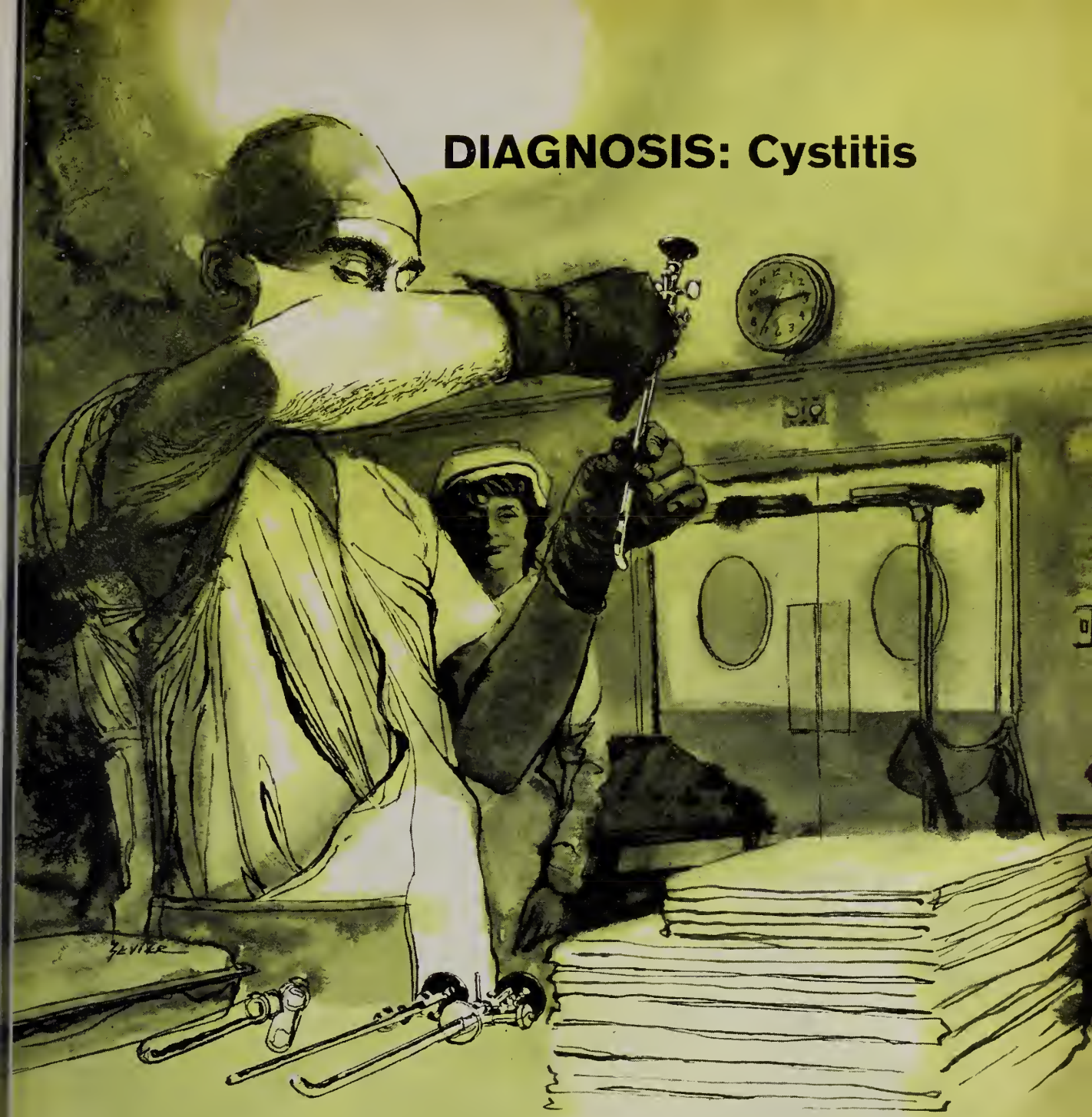


A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders. The Hospital is located in a 75-acre tract, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation. The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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NEW APPROACH TO TREATMENT OF "ATHLETE'S FOOT"

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FEAT VAPOR ACTION "in vitro" Assays

Days of Exposure	*Code*	*Feat Aerosol*	*Feat Powder*	*Control*
1	P	=	=	+
	SC	=	=	+
2	P	=	=	+++
	SC	=	=	+
3	P	=	=	++++
	SC	=	=	+
4	P	=	=	++++
	SC	=	=	+
5	P	=	=	
	SC	=	=	
6	P	=	=	
	SC	=	=	
7	P	=	=	
	SC	=	=	

CODE: P=Seeded Plate; SC=Subculture in Sabouraud Liquid Medium; + = Growth; – = No Growth

FEAT LIQUID STERETTST.M.	% (w/w)
Undecylenic Acid, N.F.	10.0
Hexachlorophene, U.S.P.	2.0
FEAT POWDER	
Undecylenic Acid, N.F.	3.0
Hexachlorophene, U.S.P.	2.0
Zinc Stearate, U.S.P. Micronized	3.0
FEAT AEROSOL	
Undecylenic Acid, N.F.	3.0
Hexachlorophene, U.S.P.	2.0
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Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most bacterial infections of unknown etiology, Panalba offers excellent chances for therapeutic success—and why it should be your antibiotic of *first* resort.

Supplied: Flavored granules for suspension, in 30 cc. bottles with dropper-stopper calibrated in ¼ and ½ teaspoonful graduations. After mixing and shaking with 25 cc. water, each 5 cc. teaspoonful of suspension will contain:
Panmycin* (tetracycline) equivalent to tetracycline hydrochloride .... 125 mg.
Albamycin* (as novobiocin calcium) ..... 62.5 mg.
Potassium metaphosphate ... 100 mg.
Usual pediatric dosage:
½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.
(*Reminder advertisement.* Please see package insert for detailed product information.)

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IN THE BOOKS

A TEXTBOOK OF OBSTETRICS: by Duncan E. Reid, M.D.; published by W. B. Saunders Co., Philadelphia; 1087 pages; price, $18.50.

The author, Duncan E. Reid, M.D., is chairman of the comparatively new combined departments of obstetrics and gynecology of Harvard University Medical School and is chief of staff at Boston Lying-in Hospital. Prior to this amalgamation of the two departments, Doctor Reid was the chairman of their obstetrical department. Hence a new book is available by one of the outstanding leaders in American obstetrics.

Based on the vast experience and material available for the Boston group, this "Textbook of Obstetrics" has a two-fold purpose. First, it is well-organized and authoritative for teaching. It affords the student material for a theoretical and a practical understanding of obstetrics. Secondly, the tremendous number of references from current literature used in each chapter provides the practicing physician a source of information that is invaluable.

Illustrations are frequent, some from other literature, but there is an excellent collection of original photographs.

There are particular phases of the discussions on treatment that are especially appealing in their common sense approach to patient care. This is noted in the chapter on "Hyperemesis Gravidarum" and equally so in the chapter on "Abortions." Comparatively few statistics are used. The author also takes the opportunity of utilizing other members of the Harvard teaching staff. This is brought out in the chapter on "Medical and Surgical Diseases in Pregnancy."

The Boston Lying-in Hospital is fortunate in having a pediatrics service. Authorities from this department contributed the chapters on blood groups, erythroblastosis fetalis and also a chapter in three parts on "The Newborn." This contribution by the pediatricians is divided into "Examinaton of the Newborn," "Neonatal Neurology" and "Management and Diseases of the Newborn." Claude A. Ville, Ph.D., contributes a chapter on "Human Genetics."

Generally speaking, another textbook on the subject of obstetrics would seem unnecessary and uninteresting. However the results show otherwise. Doctor Reid, who is one of the leaders in this field of medicine, presents a wealth of material and experience from his department while also incorporating many of the more valuable references in literature.

Rudolph F. Vogt, M.D.

The interim session of the American College of Chest Physicians will be held at the Ambassador Hotel, Los Angeles, November 24-25. For further information, contact the College at 112 East Chestnut Street, Chicago 11, Illinois.

TREATMENT OF INJURIES TO ATHLETES; by Don H. O'Donoghue, M.D.; published by W. B. Saunders Co., Philadelphia; 649 pages; price $18.50

This book is well done by both the author and publisher. The book is 649 pages long including the index and divided into 21 chapters.

The first chapter has to do with the role of the physician in the treatment of athletic injuries. The fact that the physician has a role not only in the treatment but in prevention of athletic injuries is emphasized. Also mention is made of the fact that the physician should be the sole judge of whether an injury is serious enough to limit the ability of the injured athlete to continue playing or not.

The next two chapters are devoted to the prevention of injuries and general principles of treatment. From Chapter 5 through Chapter 21 the treatment concerns itself with injuries of specific areas. For instance, Chapter 7: "Injuries of the Shoulder Girdle"; Chapter 8: "Injuries of the Upper Arm," etc.

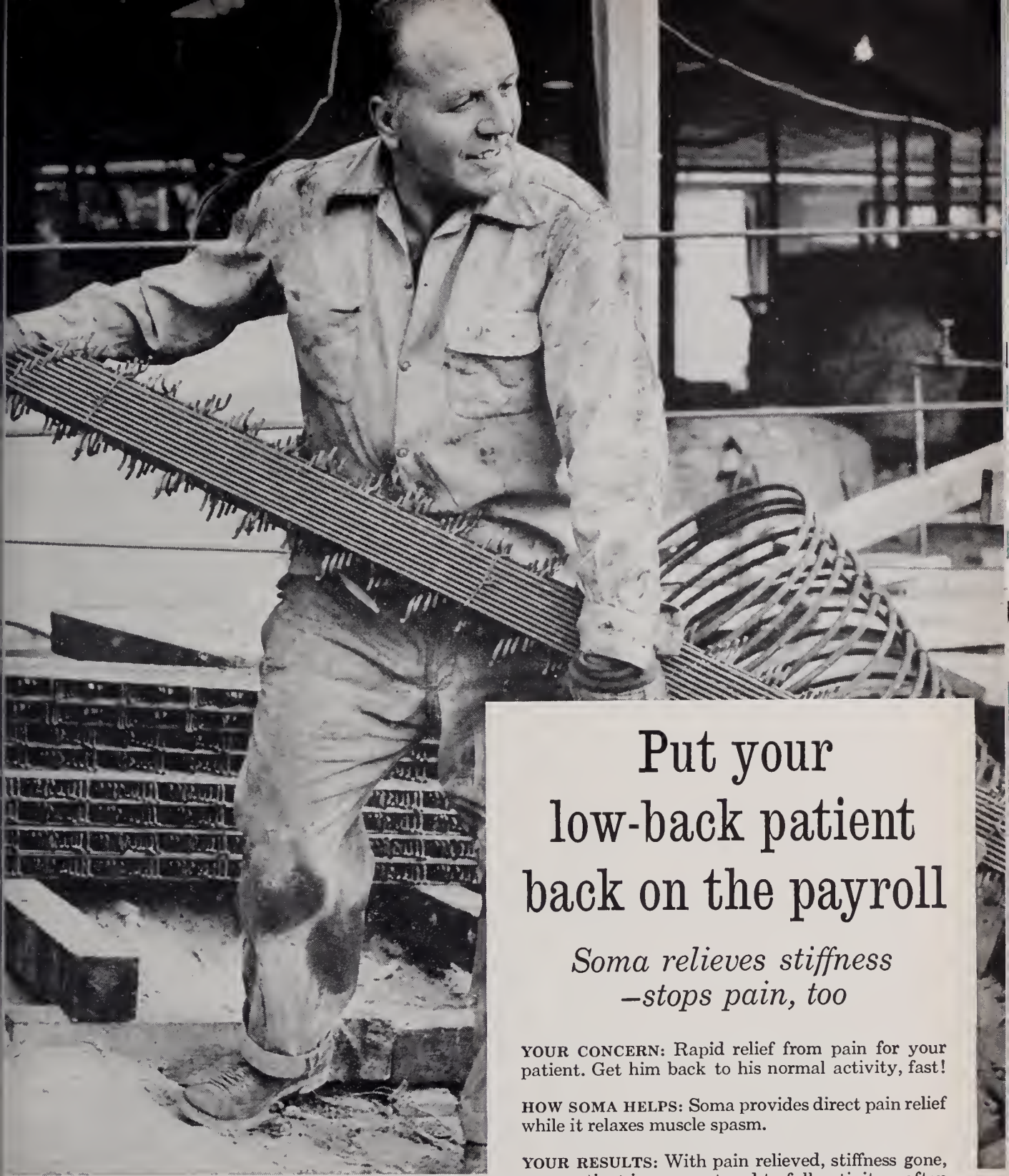
The latter arrangement is further subdivided into broad anatomical considerations to acquaint the reader with the part injured and then further subdivided into anatomical areas. This is good because it makes for ready reference to an injured area.

The material presented is good and based primarily upon the author's own experiences which have been extensive in this field. While there might be some minor differences of opinion regarding certan types of treatment it is unlikely that the reader would go wrong in applying any of the methods advocated by Doctor O'Donoghue in treatment of any of the specific injuries to athletes that might be encountered. As a matter of fact, many of the injuries discussed by the author are frequently seen as a result of industrial accidents and trauma, for example, automobile accidents.

I think that any physician treating any of the above type of injuries would benefit by having this book in his library for ready reference.

D. G. Costigan, M.D.

"The Information Explosion—Its Challenge and Problems" will be the theme of the 19th annual meeting of the American Medical Writers Association at the Sheraton Park Hotel in Washington, D. C., October 12-13. Consideration will be given to what medical journal editors, authors, educators, pharmaceutical companies, and medical writers can do to meet the challenge of the flood of new medical information. For details and registration forms contact John Sargeant, Chairman of the Local Arrangements Committee, Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore 1, Maryland.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

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> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

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Wallace Laboratories, Cranbury, New Jersey

PUBLIC HEALTH PAGE

Rabies*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE incidence of rabies has been markedly reduced by animal vaccination and control procedures during the past several years, but the entire Commonwealth of Kentucky must still be considered as an endemic area for rabies. Even in those counties which have been free from rabies for extended periods of time, the threat of an epizootic still exists due to the uncontrolled movement of infected animals, both domestic and wild, from surrounding geographic foci of infection. Consequently the practicing physician is placed in the often difficult position of deciding whether his patient with an animal bite wound has actually suffered an exposure to rabies virus, and if so what regimen of antirabies therapy is indicated.

During 1961 a total of 972 animal heads were submitted to the Kentucky State Department of Health, Division of Laboratories, for rabies diagnosis. Of these, 127 were positive, representing an infection rate of 13 per cent. The total confirmed cases by species was as follows: 69 dogs, 25 foxes, 2 cats, 20 cattle, 3 skunks, 1 raccoon, 1 hog, 2 horses, 1 mule, 1 bat, and 2 humans. Both human cases occurred in the eastern mountain area and resulted from extremity bites by rabid foxes.

With such a wide species distribution of rabies virus infection, every animal bite incident must be carefully evaluated to enable the physician to arrive at an intelligent, defensible decision as to whether or not his patient should receive antirabies therapy. Certain readily available information can be helpful and should be utilized in making this decision. For example, with domestic or pet animal bites one should know:

1. Was the offending animal vaccinated against rabies? Are there records to attest to this?
2. Is the animal kept in a pen or restricted area or does it roam at will?
3. Was the animal provoked in any way or did the bite occur without warning?
4. What is the exact location and extent of the wound?
5. Did the bite occur in or near an area known to be currently or recently endemic for wild or domestic animal rabies?
6. Was the biting animal recently shipped from an area endemic for rabies?
7. Has the animal shown any symptoms compatible with a diagnosis of clinical rabies or, if dead, has its head been submitted for rabies diagnosis?

Obviously, such complete information will not be available if the offending animal was wild or stray. However, if possible, the animal should be captured and confined for clinical observation for at least 10 and preferably 14 days following the biting incident. If the animal escapes, most wild animal bites must be considered as rabies exposures and treated as such.

Once the physician has determined that his patient has suffered an exposure to rabies virus, early initiation of post-exposure prophylactic treatment is imperative. It must be first decided whether antirabies serum produced from the hyperimmunization of horses will be administered. In general such serum is indicated in all cases where a short incubation period can be anticipated, especially in cases of multiple or severe wounds, or those located on or near the face, head, fingers, or neck. Next a choice of vaccines must be made between those of nervous tissue or avian embryo origin. The commercially available duck-embryo origin rabies vaccine has steadily increased in popularity as its use precludes the development of an allergic encephalomyelitis, an occasional complication of brain tissue or Semple vaccine therapy. Local allergic serum and vaccine reactions can be reduced, without interference with production of active antibody, by the administration of antihistamines. If hyperimmune serum is used the standard course of 14 daily doses of vaccine should be followed by two supplemental injections of vaccine, 10 and 20 days after the last usual dose.

The Kentucky State Department of Health, Division of Veterinary Public Health, has recently excerpted the Fourth Report of the W.H.O. Expert Committee on Rabies and has made copies of this report, "Rabies Treatment of Man," available to all physicians in the state. Copies can be secured on request through the local health department in your county. Furthermore, the Division staff will be happy to consult with physicians on any question regarding the perplexing problem of rabies.

---

*This article was prepared by:
J. W. Skaggs, D.V.M., M.P.H.,
Principal Veterinarian,
Division of Veterinary Public Health,
Kentucky State Department of Health,
Frankfort, Kentucky.



NEW PORTABLE CAMBRIDGE EXTERNAL DEFIBRILLATOR

SIMPLIFIES
SPEEDS
STANDARDIZES
CARDIAC
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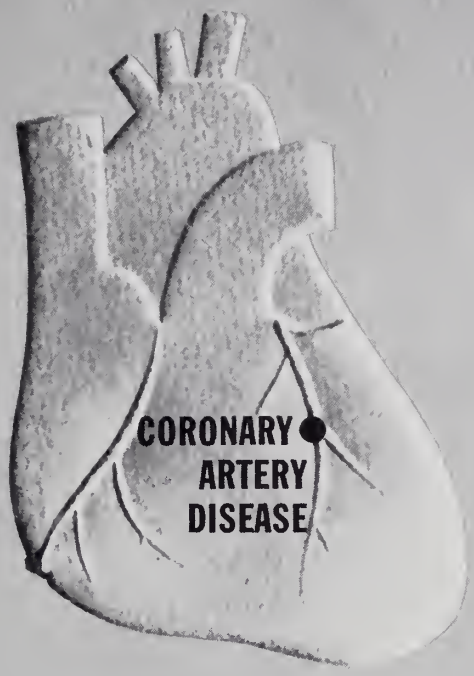
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Symposium on Infectious Diseases

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KENTUCKY STATE MEDICAL ASSOCIATION ORGANIZED 1851

OCTOBER 1962 · VOLUME 60 · NUMBER 10

in urinary tract infections...
the most common pathogens
respond to



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Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Katz, Y. J., & Bourdo, S. R.: *Pediat. Clin. North America* **8**:1259, 1961. (2) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Whitaker, L.: *Canad. M. A. J.* **84**:1022, 1961. (6) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959.

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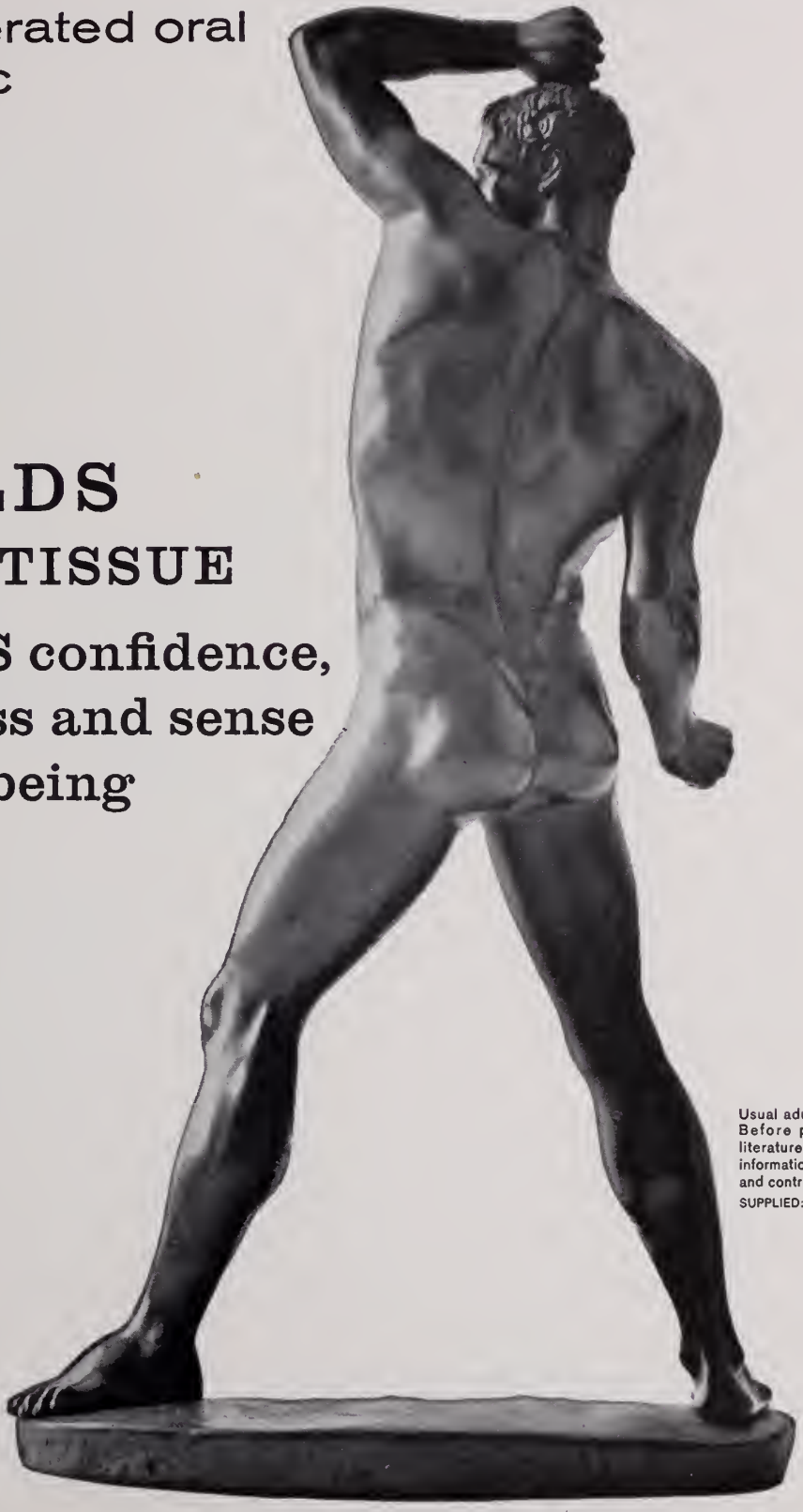
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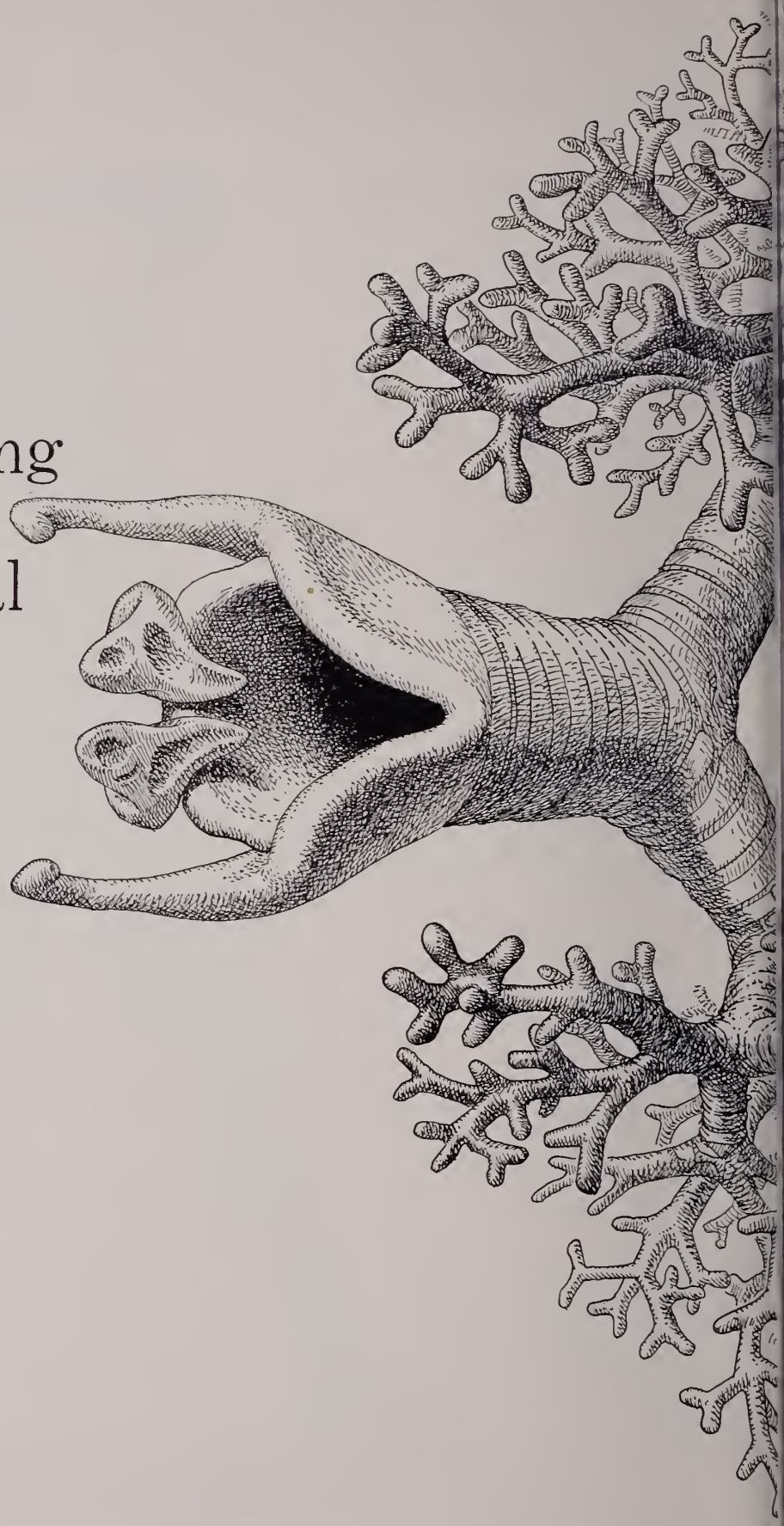
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MESSAGE FROM THE PRESIDENT

KSMA Enters Another Year

THE Kentucky State Medical Association is entering another year. As your new president, I wish to thank each member for his or her confidence and trust. The responsibilities are manifold and I assure you that I shall fulfill these to the best of my ability. The care of the sick is our first duty. The preservation of medical principles and the protection of the integrity of our profession must be maintained.

Never was our profession faced with so many problems vital to the practice of medicine. These problems are local, state, national and international. All people, old or young, rich or poor, slightly or seriously ill, should have the privilege of selecting the doctor they want to treat their infirmity. Government legislation, insurance companies, hospital associations and local communities are beginning to recognize this factor as one of the inalienable symbols of our great country.

The officers of the KSMA are willing and anxious to give their time and talent in trying to solve our medical and our political problems. However, it takes every member of our profession doing his job ethically and conscientiously in the community that he has chosen to live in, not only to treat the ill but to be active in as many community activities as time will permit. Very important among these is to use your influence in electing political officers, regardless of their political party, who believe in private enterprise and who will vote to preserve constitutional government and who will also vote to prevent any increase in socialization of our country.

The Auxiliary has an excellent opportunity in the November election to work on the precinct level to get people out to vote and to actively support the conservative candidate who believes in individual integrity and who is against all forms of collectivism.

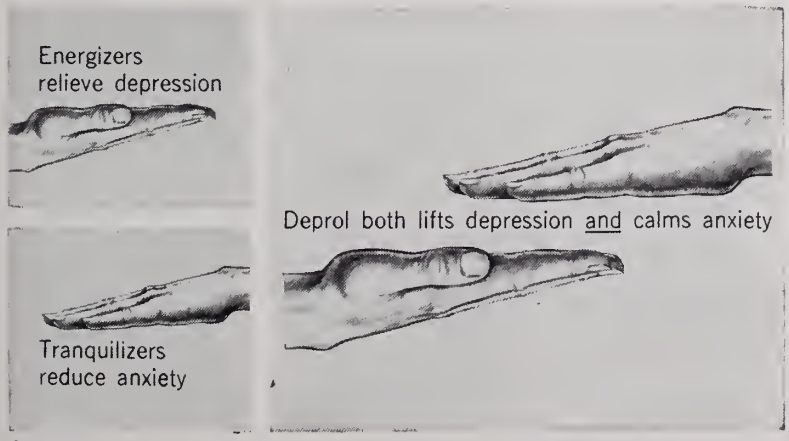
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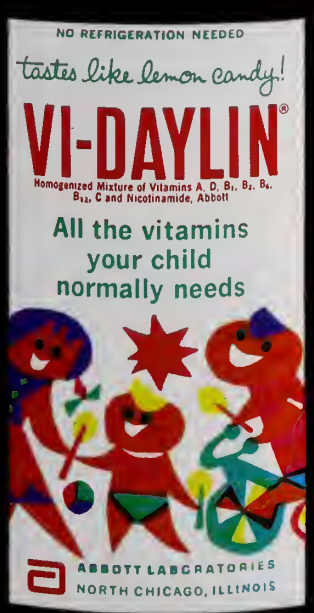
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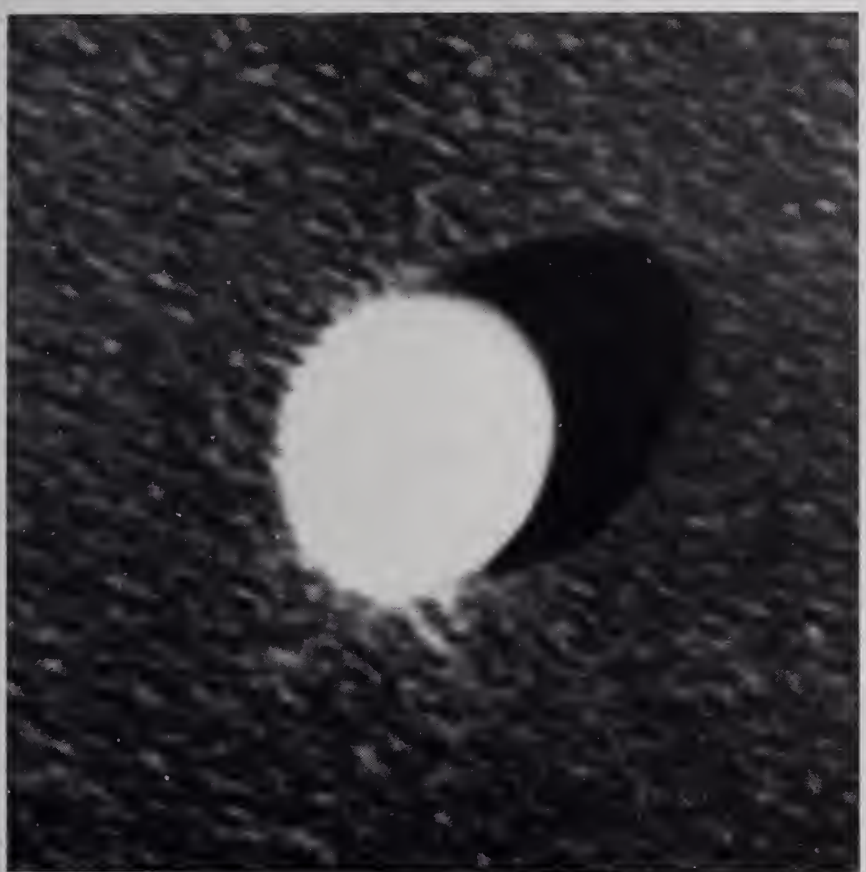
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THE INSURANCE PAGE



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SEVERAL months have elapsed since the proposed Blue Shield-Blue Cross National Senior Citizens program was first announced to the public.

This plan, which was given the full support of the American Medical Association and of the American Hospital Association, was acclaimed enthusiastically by most of the press as a great step forward in providing adequate health care for our older people on a voluntary basis.

During the ensuing months, an enormous amount of work and preparation have taken place. In order for the plan to be implemented, it was necessary that it first be studied and acted upon by each of the component medical societies and each of the Blue Cross and Blue Shield plans in our country, since the parent organizations which developed and sponsored the plan (the American Medical Association, the American Hospital Association, the National Association of Blue Shield Plans and the Blue Cross Association) exist only as *federations* of autonomous organizations, each of which had the power to accept or reject the program.

It soon became apparent that the original intent of pooling the funds from all the Blue Shield plans in order to permit the writing of uniform benefits at uniform premium rates throughout the country was not feasible. For one thing, some insurance commissioners would not permit such an arrangement for the plans under their jurisdictions. In addition, some of the Blue Shield plans felt that they were already offering better benefits at lower premium rates than did the new uniform national contract.

It was finally decided, therefore, to allow each plan, under the sponsorship of its medical society, to determine its benefit schedule and premium rates on a local level, thus giving more flexibility to the plans as a whole.

Plans for a national advertising program were retained and are being implemented. In the very near future several of the leading national magazines, including *Life, Look, Saturday Evening Post, Time* and *Newsweek,* will have come out with large and impressive advertisements concerning the national Blue Cross-Blue Shield coverage for the aged. In many areas this will be supplemented by local advertising in the press and on radio and TV.

Of the 70 Blue Shield plans in our country, only one has refused to participate in the National Senior Citizens program. Almost 50 of the plans, including the Kentucky Blue Shield Plan, will offer the same benefits, on a full coverage basis to eligible persons, which were originally proposed in the Uniform National Contract.

Most of the remaining plans will also offer full coverage to senior citizens in the low income group. Those plans which will offer only indemnity benefits will have the support of their medical societies in urging that the benefits be accepted as full payment, in most cases.

As far as Blue Cross is concerned, all of the plans in this country have agreed to participate in a uniform program. Many of the Blue Cross plans will also offer, on an optional basis, an additional contract having higher benefits, at higher premium rates. Each of these will be offered in conjunction with a corresponding Blue Shield program.

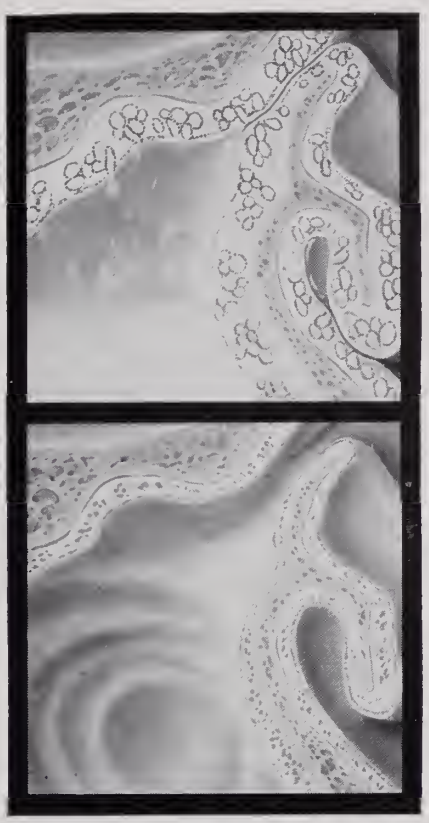
There is still one detail to be accomplished in Kentucky before this program finally "gets off the ground." This will be the enrollment of the participating physicians.

Within the near future, at this writing, every physician in Kentucky will be given the opportunity to sign a participating physician's agreement, by which he signifies his willingness to take part in the program.

As soon as this enrollment period for the

(Continued on Page 1003)

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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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IN THE BOOKS

Poliomyelitis*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE incidence of paralytic polio has been markedly reduced by Salk Vaccine. As recently as 1952 Kentucky reported *1,762* cases of polio in one year with *129* deaths. With the advent of the widespread use of Salk Vaccine, the incidence of polio in Kentucky steadily decreased to a total of only 28 cases in 1961.

As of this date, there have been only 15 cases of polio and no deaths during 1962. All of these current cases could be classified as mild and for the most part demonstrate no residual paralysis. Three of the 15 cases had received Salk injections; one had received two, and two had received only one injection. None of the victims had received boosters in recent years.

Over all, the development of Salk Vaccine can be considered as a major step in the control of this dreaded crippler, polio. However, we no longer think about merely controlling polio but are now concentrating on complete eradication. Most authorities are convinced that the tool is now at hand to accomplish this goal.

The tool for eradication of polio, of course, is the Sabin Oral Vaccine. With the enthusiastic report this vaccine has received from medical societies and public health officials, it is believed that approximately 90% of all Kentuckians will have protection against polio by the 1963 polio season.

The State Health Department recommends and encourages full use of Sabin Oral Vaccine for everyone even though they may have had full protection with the Salk Vaccine. This recommendation is based on the following:

1. *Ease and speed of administration.* Thousands of people can be immunized in a few hours.

2. *Herd immunity or contagious immunity.* Since this is a live attenuated virus it is spread in the same manner as the pathogenic virus. Therefore, close contacts of family members who have not received the vaccine may nevertheless be immunized by natural transmission of vaccine virus.

3. *Since the vaccine is given orally it is painless.* Fear of the pain which accompanies a hypodermic injection is completely avoided. Therefore, now people readily accept the vaccine. (It is surprising to see the large number of parents who will take their children to clinics for polio shots but will not themselves submit to the needle.

4. *Sabin Oral Vaccine eliminates the carrier state.* People who are adequately immunized with Salk Vaccine may still remain as carriers. With Sabin's vaccine virus, complete tissue immunity precludes the carrier state in vaccinates.

5. *Sabin Vaccine is type specific.* If cases of polio occur in a given area, typing can be done immediately. Then the specific type vaccine may be used to immunize the population in the area against the epidemic strain to which they are being exposed.

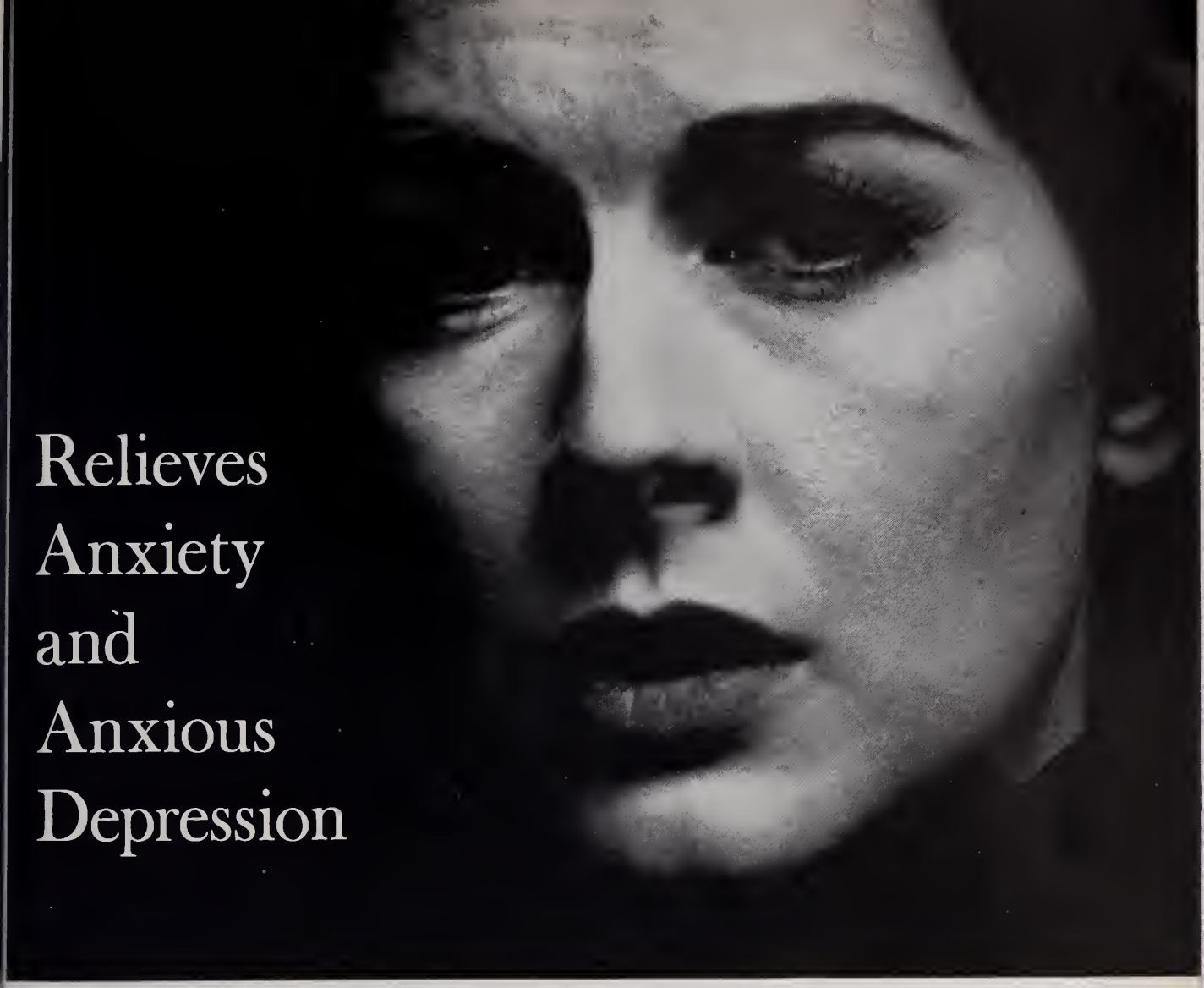
6. *Sabin Vaccine gives faster immunity.* A protective antibody titer can be built up within three weeks. Several months are required to have adequate protection from Salk Vaccine.

During the past few months "Sabin Oral Sundays" (SOS) have been sponsored by many medical societies and county health departments throughout the State.

At this time the vaccine has been offered to approximately one-half of our population. On October 7, 21 counties sponsored programs offering the vaccine to more than 1,000,000 Kentuckians. Hopefully this trend will continue until every Kentucky resident has had the opportunity to receive the best available protection against poliomyelitis—Sabin Oral Vaccine.

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*This article was prepared by J. Clifford Todd, M.P.H., state epidemiologist, Division of Preventive Medicine, Kentucky State Department of Health, Frankfort, Ky.



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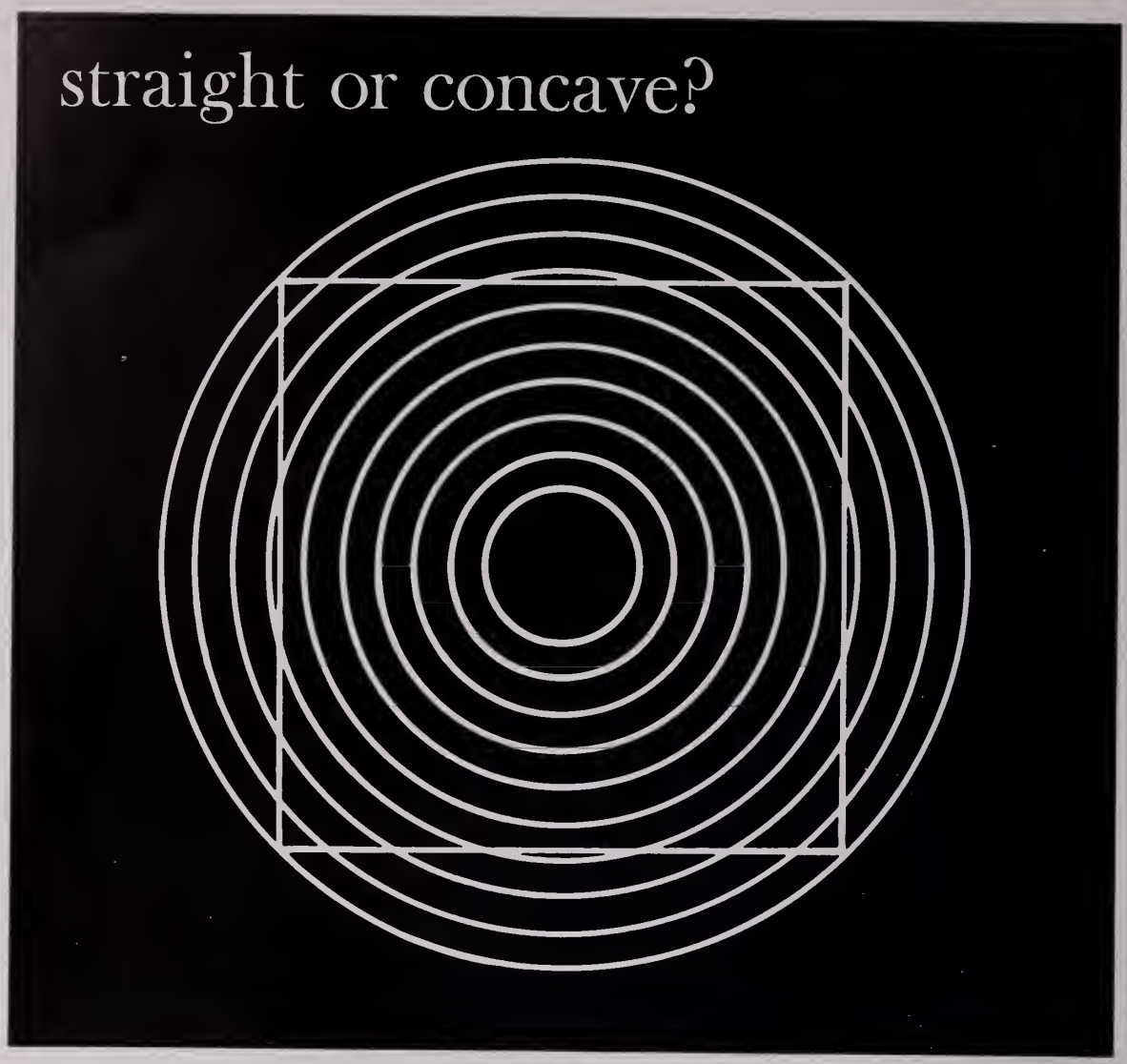


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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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Symposium on Infectious Diseases

Recent Advances in Clinical Virology

MICHAEL J. MCNAMARA, M.D.*
Lexington, Ky.

SOON after the introduction of tissue culture techniques into the virus laboratory, the medical literature became rife with reports of new virus isolations. The onerous task of classifying and naming these newly recognized microbes fell to the virologist. Furthermore, their etiologic function, if any, in the production of human disease clamored for immediate investigation.

As epidemiologic studies progressed, their high prevalence and ubiquity in the human population became established. Indeed, it is rare for an individual to escape infection with a number of these agents before reaching adulthood. For many of the newly recognized viruses, their etiologic importance in certain human disease states has been confirmed, but others still await this confirmation and have been duly designated "Viruses in Search of Disease."[1]

The purpose of this communication is to review the more recent advances made in the field of clinical virology and attempt to interpret the implication of these discoveries with respect to the prevention of disease and their long-range significance in human pathology.

This is the oldest of the new. These viruses were first isolated from apparently healthy adenotonsillar tissue, in 1953, by Rowe et al.[2] Following rapidly on this, a similar agent was associated with the acute respiratory disease syndome (ARD) in military recruits.[3] Subsequently, numerous viruses, sharing a common complement fixing antibody but differing from each other by the production of type-specific neutralizing antibodies, were discovered. Because these viruses were first discovered in human adenotonsillar tissue, they were finally christened "adenoviruses". Of the 18 human types thus far discovered, only six or possibly seven have been associated with certain disease syndromes. Table I lists in summary these disease states. (See next page.)

Present epidemiologic data on adenoviruses have shown different age-specific prevalence patterns. Many studies have demonstrated that most adenovirus infections occur during infancy and early childhood.[4] Types 1, 2 and 5 are particularly active in this age group.

The Journal of the Kentucky State Medical Association presents its fifth annual Scientific Symposium with Beverly T. Towery, M.D., Louisville, as Special Symposium Editor. Doctor Towery is chairman of the Department of Medicine, University of Louisville School of Medicine.

*Assistant professor of Community Medicine, University of Kentucky College of Medicine, Lexington, Ky.

TABLE I
Some Clinical Syndromes Associated with Adenovirus

Syndrome	Most Common Types	Population
Acute Respiratory Disease (ARD) Pneumonia without Cold Agglutinins	4, 7, less common 3	Military Recruits.
Pharyngoconjunctival Fever (PCF)	3	Epidemic in children; sporadic in adults.
Acute Febrile Pharyngitis Febrile Common Cold	1, 2, 3, 5	Endemic in infants and young children.
Epidemic Keratoconjunctivitis (EKC)	8	Common in Japan; rare in U. S.
Virus Pneumonia in Infants	7a	Occurred in hospital nursery; rare.

Adenovirus type 3, often associated with the syndrome of pharyngitis, conjunctivitis and fever (PCF), occurs in epidemic form both in children and to a lesser extent in adults. Types 4 and 7 have a high prevalence in military populations and are frequently associated with epidemics of acute respiratory disease (ARD). Clinically, this illness in recruits presents as a febrile undifferentiated upper respiratory infection or a primary exudative pharyngitis. In addition to upper respiratory infection adenovirus, particularly types 4 and 7 have been isolated from hospitalized recruits suffering from viral pneumonia and in whom there was *no rise* in cold agglutinins or streptococcal MG antibodies.

Chany et al. reported on a severe epidemic of pneumonia in Paris involving infants and children. Of the 20 cases of pneumonia described, there were three deaths. Adenovirus type 7a was the offending agent. Lastly, adenovirus type 8 was isolated from patients suffering with keratoconjunctivitis. This disease most frequently occurs in patients who sustain chronic corneal trauma due to foreign bodies, e.g., arc-welders.

Although adenoviruses are contributors to man's ills, particularly during childhood, they have been found responsible for only a very small portion of the total respiratory disease of the general population. Jordan and others[5, 6] have shown that they account for 2% to 6% of this illness. With the exception of military recruits, adenoviruses appear only sporadically in outbreaks of adult respiratory disease. Therefore, protection of the general population with specific adenovirus vaccines is not recommended. Large-scale vaccination programs against types 4 and 7 have been in effect for the last few years in military recruit populations, where they have produced a marked reduction in the number of hospitalizations due to these agents.[7]

Myxoviruses and Other New Respiratory Disease Agents

Myxoviruses

Some of the characteristics necessary before a virus can be labelled a myxovirus are: (1) size, 80-150 mu, (2) ability to agglutinate chick red blood cells, and (3) the presence of a red blood cell receptor destroying enzyme (RDE). Included in this group of viruses that have significance in human pathology are: (1) the influenza viruses types A, B and C. (2) mumps virus and (3) the recently discovered parainfluenza viruses types 1, 2 and 3. Since an excellent review of the clinical and epidemiological aspects of influenza has recently been published, this discussion is limited to the more recent additions to the myxovirus group.[8]

Parainfluenza Viruses

In 1955 a virus was isolated in monkey kidney tissue culture from children suffering with croup. It was termed "CA virus" (croup-associated).[9] Studies revealed this virus to be a myxovirus but antigenically distinct from the influenza viruses type A, B and C. Subsequently, it was reclassified as parainfluenza type 2. Its association with croup has been noted in two separate studies. In 1958 Chanock and his associates reported the isolations of a number of agents in monkey kidney cultures by use of the hemadsorption technique,[10] e.g., the presence of virus growth in the tissue culture is indicated by the adsorption of guinea pig red blood cells to the monolayer of tissue even in the absence of significant cytopathic effect. Two serologically different viruses were distinguished; the hemadsorption type 1 (HA-1) and hemadsorption type 2 (HA-2). These two

agents are now known as parainfluenza type 3 and type 1, respectively.

Another new myxovirus which has been added to the group is the Sendai virus or hemagglutinating virus of Japan (HVJ). This agent was isolated in the embryonated hen's egg from infants with pneumonitis in Sendai, Japan. Although serologically distinct from the members of the influenza viruses, this agent did produce an influenza-like illness in human volunteers and was once designated as influenza D. Recently it has been regarded as a subtype of the parainfluenza 1.

A serological diagnosis of parainfluenza can be made by observing a rise in complement fixing, hemadsorption inhibiting, hemagglutination inhibiting or neutralizing antibodies. As mentioned previously, the parainfluenza viruses are distinct serologically from the influenza group, but, because of a number of serological cross-reactions between the various parainfluenza viruses, particularly when human serum is used in the titration, it is now believed that the members of this group share some common antigens.

Parainfluenza 2 (CA)

Clinically, parainfluenza 2 (CA) has been most frequently isolated from infants with laryngotracheobronchitis, but more clinical and epidemiologic information is needed. On the other hand, the clinical picture resulting from infection with parainfluenza 1 and 3 in children may range from a mild afebrile rhinitis to laryngotracheobronchitis and bronchopneumonia. Approximately 10% to 15% of children acquire infection with parainfluenza 1 during the first two years, and this increases with age until about 70% of adults show serological evidence of previous infection. This virus is considered the most common cause of infantile croup of cases thus far studied. The parainfluenza 3 infections occur most frequently in childhood. By the end of the first year nearly 50% of children have serological evidence of infection, and 100% of adults have such evidence. Both human volunteer studies and epidemiologic observations of children have demonstrated that reinfection with this agent can occur, but that the illness produced is much milder.

In general, the parainfluenza 1 and 3 viruses are very prevalent and infect during every month of the year. It is a disease of childhood, but there is some evidence that a mild reinfection illness occurs in the adult.[11]

Other New Respiratory Disease Agents

The Respiratory Syncytial virus (RS) was first isolated from chimpanzees suffering from coryza and, subsequently, by Chanock and his associates, in children with croup and bronchiolitis. It has been named the "Respiratory Syncytial" agent because of the distinctive syncytial pattern the virus produces in the appropriate tissue culture system. This virus is a very important cause of bronchiolitis and pneumonia in infants and small children. In human adult volunteers studies, the agent produces mild, non-specific, upper respiratory infection. This subdued clinical picture may represent a reinfection type of illness.[12]

The JH/2060 virus was isolated from individuals with the common cold syndrome, both in civilian and military populations.[13, 14] It has since been classified as an ECHO 28 virus and is believed by many investigators to be one of the causes of the common cold. More intensive epidemiologic investigation is needed to define the exact role of this agent in human respiratory disease.

The Reoviruses (formerly ECHO 10) were first isolated from healthy children by Sabin. The Reoviruses consist of serotypes 1, 2, and 3, which share a common complement fixing antigen. This virus is interesting in that it has properties of both the myxovirus group and the enteroviruses although it forms a distinct group of its own.[15] The virus has been associated with mild respiratory infections in infants and adults. There is also some evidence that infection with this agent can cause diarrhea in infants.

Coe Virus

Another virus which has recently been associated with outbreaks of predominantly mild respiratory disease, since its isolation by Lennette from military personnel, is the Coe virus; now reclassified as Coxsackie Group A, Type 21. An extensive epidemiologic and virologic study of this virus has recently been reported

following an outbreak of mild respiratory disease in a Marine training camp.[16, 17]

Two of the most recent and exciting discoveries in the investigation of the etiology of respiratory diseases have been the isolation of the "common cold" virus by Tyrrell and his associates and the studies of Chanock and associates which established a pleuropneumonia-like organism (PPLO) as the Eaton agent responsible for positive cold agglutinin "atypical" pneumonia. In 1960 Tyrrell reported the successful cultivation of two virus strains—H.G.P. and F.E.B.—from adults suffering from the common cold. The viruses grew and produced cytopathic effect in human-embryo-kidney cells. The unique features of these "common cold" viruses are that they are best cultivated at 33° C. and in a medium with a lower pH in the range of 6.8 (usual pH is 7.2-7.4).[18] These findings have been confirmed by other investigators, and further studies are in progress to delineate the properties of these viruses and study their epidemiology.

For some time clinicians have been aware of the fact that certain cases of primary atypical pneumonia (PAP) seemed to respond to antibiotics. Eaton first reported the isolation of an infectious agent in PAP with positive cold agglutinins. Sero-epidemiological studies in military recruits, students, adults and children have recently established the association of Eaton agent with positive cold agglutinin PAP.[19] Treatment of this disease with demethylchlortetracycline shortened the illness and accelerated X-ray clearing.

Following the lead of Marmion and Goodburn,[20] Chanock and associates offered strong evidence that the Eaton agent associated with positive cold agglutinin PAP is a PPLO.[21] This is the first positive identification of this organism as an agent in human disease. A recent article in *Scientific American* contains an excellent treatment of the nature of this very interesting organism.[22]

The Enteroviruses

The three members of the enterovirus group are polio, Coxsackie and ECHO viruses. The criteria for the inclusion of a virus in this group are, among others, its size (usually small, 25-35 mu.), its resistance to treatment with ether and its ability to multiply in the human intestinal tract and in monkey kidney tissue culture.

TABLE II
Clinical Syndromes Associated with Coxsackie Viruses

Group A (24 types)

Syndrome	Type
Herpangina	2, 4, 5, 6, 8, 10
Aseptic meningitis	4, 7, 9
Paralysis	7, 9, 23 (formerly ECHO 9)
Pericarditis	1
Exanthem	9, 16, 23
Acute respiratory disease	21 (formerly Coe virus)
Non-specific febrile disease	Probably many of the above

Group B (6 types)

Syndrome	Type
Pleurodynia	1-5
Aseptic meningitis	1-6
Paralysis	3-5
Myocarditis and meningo-encephalitis	2-5
Pericarditis, myocarditis	2-5
Non-specific febrile disease	Probably all 6 types.

The enteroviruses maintain a very high prevalence in the human intestinal tract. This high carrier rate occurs particularly in the warmer months of the year and in the low socio-economic districts. Although endemic, a number of these agents have been responsible for local and widespread epidemics. The clinical disease varies from a mild, non-specific, upper respiratory illness to central nervous system paralysis, myocarditis and pericarditis.

The polioviruses were first isolated by Popper and Landsteiner in 1909. Studies eventually established that there are three serotypes. Since there have been no changes in the group for the last decade, further comment on these viruses is omitted except when pertinent in the discussion of the Coxsackie and ECHO viruses.

Coxsackie Viruses

The Coxsackie viruses were isolated by Dalldorf and Sickles in 1948 from the stools of children during a poliomyelitis epidemic in the village of Coxsackie, N. Y. These agents have been divided into Groups A and B on the basis of the histopathology produced in suckling mice. Those of Group A produce flaccid muscular paralysis with extensive round cell infiltration, whereas Group B viruses produce lesions primarily in the central nervous system and other viscera, but only focal muscular involvement. In addition to suckling mice, tissue culture systems, particularly Hela and monkey

kidney, are used for the isolation and study of these organisms. Optimal conditions for isolation require that both suckling mice and tissue culture be used.

At this writing there are 24 subgroups or types for the Group A Coxsackie virus and six for the Group B. The clinical syndromes produced by these viruses are presented in Table II. The ability of these viruses to involve a number of organ systems is quite characteristic of many enteroviruses. They are now well established etiologic agents in herpangina and the "Devil's Grip" (pleurodynia). They have also been associated with fatal myocarditis in infants and the syndrome of benign pericarditis in the adult. Both Groups A and B have been responsible for outbreaks of aseptic meningitis. In addition, Coxsackie A-7 has been associated with the syndrome of paralytic poliomyelitis in Russia and the United States. Biologically, this particular virus shares many properties in common with both the Coxsackie and polioviruses.[23] Although capable of causing severe and fatal disease, these agents have also been responsible for several small outbreaks of febrile illness with generalized rubelliform rash and mild upper respiratory disease, e.g., Coxsackie A-21, formerly Coe virus.

ECHO Viruses

Enteric cytopathogenic human orphans, or ECHO viruses, consist of 28 types. They possess the properties necessary for inclusion in the enterovirus group, but are serologically distinct from both the Coxsackie and polioviruses. These are non-pathogenic for suckling mice and grow readily in human and monkey kidney cell cultures. The ECHO viruses were first isolated from healthy individuals, and the "orphan" referred to their non-association with illness.

It was originally planned that once a particular strain was associated with a certain disease syndrome, it would be removed from the orphan group and renamed. But it soon became evident that these agents form a serologically and biologically distinct group, and despite their relationship with certain disease states, their original designation of ECHO has been retained. Two exceptions to this are the reclassification of ECHO 9 as Coxsackie 23, because of its mouse pathogenicity, and ECHO 10 as the Reovirus, because of its size and other biologic properties.

TABLE III
Clinical Syndromes Associated with ECHO Viruses

Syndrome	Type
Aseptic meningitis	4, 6, 16, 19
Paralysis	6, 16
Exanthem	1, 2, 4, 6, 11, 14, 16
Diarrhea	14, 18
Respiratory infection	4, 8, 11, 20, 28

The ECHO viruses share a worldwide distribution with the other enteroviruses. Many of the strains have been associated with well documented episodes of sporadic and epidemic outbreaks of illness. Nevertheless, a number of strains still remain orphans in search of disease. Clinically, a number of the syndromes produced do not differ from those associated with the Coxsackie group, that is, these agents are capable of producing mild respiratory diseases, aseptic meningitis and exanthem diseases. Some strains appear to be paralytogenic, but to date there has been no evidence of severe or long-term paralysis following such infection. Infant diarrhea has been associated with a number of enteroviruses. Thus far, the strongest evidence for such illness has implicated ECHO 18 and 14. Table III summarizes our present knowledge of the clinical disease associated with these agents. An extensive review of the clinical aspects of enterovirus infections has been prepared by Dr. T. F. McNair Scott.[24]

The association of these agents with respiratory disease has recently received new emphasis. The JH/2060 virus previously discussed is now classified as ECHO 28. Cramblett reported on the isolation of ECHO 20 from children with mild resporatory disease. A strain of ECHO 11 (U virus) was isolated from children with croup in 1956-57 and has since been associated with afebrile respiratory disease in children and following inoculation of adult volunteers. Also, the "common cold" virus isolated by Tyrrell has some properties which suggest that it might be related to the ECHO group.

Comment

What, then, is the significance of so many new viruses? Most of the infections produced by them are mild or inapparent. Indeed,

clinically it is impossible to distinguish an isolated acute upper respiratory infection as one caused by Coxsackie, ECHO or adenovirus.

Aside from the transient misery they produce and the enormous toll of man-hours lost in industry, should they not be dismissed as having little significance in human pathology? Unfortunately, our knowledge of them is still inadequate to support such an arbitrary action. The fact that the acute disease is mild does not preclude the possibility that the long-term pathology might be severe. Epidemic studies have shown that these agents are very prevalent and have the ability to establish infection in the susceptible child and young adult.

Many strains are known to attack both the cardiovascular and central nervous system. Although in the course of an insignificant infection damage to these vital organs may be inapparent, nevertheless, with subsequent growth of the individual and accumulated stress, such pathology may become overt and eventually express itself clinically in such vague terms as "heart disease of unknown etiology" or "non-specific degenerative disease of the CNS".

In truth, these remarks are speculative, but even from this brief review one can find justification for them. If anything, our knowledge of these newly recognized agents is fragmentary. Any definite statements with respect to the full extent of their contribution to human disease must await integrated, detailed and continuous clinical and laboratory studies. For a full appreciation of the ecology of these viruses, such studies must include individuals who are apparently well, not so sick and very sick.

Such studies are expensive, tedious and time consuming. Should their results be awaited before instituting preventive measures in the form of vaccines? There is no clearcut answer to this question. Such a vaccine, to be effective, would have to contain many antigens. This alone would be a formidable technical problem in its production.

The administration of this polyvalent vaccine should be at first purely experimental. A number of well controlled and designed vaccine studies will be necessary. These studies would help establish the etiologic relationship of certain agents to particular disease syndromes. If vaccines were shown to be effective, presumably, in some populations, they could prevent 30% or more of the acute viral diseases. Although such studies are important and no doubt will be the concern of many investigators, it is realized that they are no substitute for the continued epidemiologic and ecologic study of infectious disease in human communities.

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The Clinical Microbiology of Purulent Meningitis

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THE PROPER care of patients with purulent meningitis is dependent upon the establishment of a correct diagnosis. This diagnosis may be made from a thorough clinical examination supplemented by cytological and chemical studies of the spinal fluid. An exact diagnosis, however, is afforded only by the isolation and identification of the etiologic agent.

There are several excellent reviews on the subject of meningitis[7, 12, 14, 19, 22] as well as many reports on the incidence of meningitis caused by obscure or lesser known organisms.[4, 9, 10] There is, however, one aspect which requires further emphasis and that is the clinical microbiologist's approach to the diagnosis of meningitis.

The purpose of this paper is to present some of the current microbiologic techniques that are employed to make an etiologic diagnosis. In addition some of the necessary precautions, pitfalls to avoid and interpretation of the results will be discussed.

Lumbar Puncture

It is generally agreed that a lumbar puncture should be performed immediately on all patients who show signs of meningitis.[14, 17, 19] Rarely some[12] defend the philosophy of treating patients with suspected meningitis prior to obtaining a spinal fluid specimen because meningitis is considered such an emergency that treatment should be instituted at once to avoid a fatal outcome. This is a decision that every physician must make for every case of suspected bacterial meningitis. It should be emphatically stated that such early treatment will, in all likelihood, eliminate positive identifying signs and symptoms and seriously reduce the possibility of making an etiologic diagnosis.

The routine chemical, cytologic and microbiologic examinations of the spinal fluid constitute an essential part of the diagnosis and should be done almost without exception even in those instances where complete laboratory facilities are not immediately available. The lumbar puncture should be performed and the spinal fluid sent (preferably by courier) to the nearest reliable laboratory.

There is no argument that delay in examination of spinal fluid may be reflected in unreliable chemical and cytological results but the prospects of obtaining a positive culture are still good—at least much better than after the spinal fluid contains a detectable level of an antibiotic. The spinal fluid sugar and protein provided adequate nutritional requirements for bacterial growth *in vivo* and will support the growth of the same bacteria for a reasonable period *in vitro*.

Send Fluid At Once

Optimally the spinal fluid should be sent to the laboratory at once; the specimen should be examined immediately and handled with extreme care since it represents a potentially dangerous and concentrated source of pathogenic microorganism. This precaution is often neglected and all pipettes, counting chambers, cov-

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(*The patient with clinical evidence of acute meningitis requires immediate hospitalization unless circumstances absolutely preclude such care. The hospital must assure adequate facilities to provide at least the basic initial examination of the spinal fluid, viz: Total and differential leukocyte counts and study of Gram-stained smears of the sediment. Otherwise the physician must assume the responsibility for performing these essential studies.—Editor*)

er slips, etc., should be handled carefully and be placed in a suitable germicidal solution before being used again. A portion should be centrifuged at 2500 rpm. for 10 minutes and during this time another portion should be used for the total cell count and a differential count. The centrifuged and resuspended sediment of spinal fluid is used as the inoculum for the various media to be employed and to prepare smears or films to be stained by whatever techniques are indicated. India ink or KOH wet mounts are often of great value when a fungus infection is suspected.

For all bacterial infections except tuberculosis the Gram stain is routinely employed and is still considered to be the best single staining procedure available. It is also desirable to prepare a second smear and stain it with methylene blue; such stained smears are often useful in revealing bacteria that are not observed on the Gram stained smear (usually due to the lack of contrast between the Gram negative organisms and the similarly stained white blood cells).

Value of Gram Stained Smear

The value of the Gram stained smear cannot be overemphasized. In most instances the examination of the smear will give a strong presumptive diagnosis and will materially aid the physician in his choice of antibiotic therapy.[17] This examination will also be useful in confirming the differential count of white blood cells present in the spinal fluid, in guiding the microbiologist in his choice of media for culturing the spinal fluid, and in revealing the rare mixed meningeal infection. If the smear shows Gram negative bacilli that are morphologically suggestive or typical of *Hemophilus influenzae* this finding can be confirmed by performing the capsular swelling test using some of the spinal fluid sediment and commercially available antisera of the three most common of the six types of *H. influenzae*.

Because of the importance attached to the examination of the Gram stained smear it is essential that the staining procedure be performed correctly. There are several modifications of the original procedure, any one of which is acceptable provided the directions are followed accurately. Burke's modification[6, 15] is one that has been found to be reliable even in the hands of the inexperienced. However, care must be taken with the decolorization because the Gram positiveness or Gram negativeness to a large extent depends on this one step. If decolorization is done with too much vigor, pneumococci are easily mistaken for meningococci; if decolorization is not complete, a more serious error may occur in that the influenza bacillus may be mistaken for pneumococci or streptococci.[1]

Media Are Inoculated

Once the Gram stained preparation has been examined the proper bacteriologic media are inoculated from the sediment so that the responsible organism may be isolated and identified and antibiotic susceptibility tests can be performed. There is no consensus among microbiologists as to what medium should be inoculated to yield a good growth of the observed or suspected pathogen. To a large extent this is determined by the resources of the laboratory and the training of its microbiologist.

Too frequently laboratories are understaffed and the personnel inexperienced. This often leads to the use of a single medium, usually a blood agar plate, which is theoretically endowed with the magic ability to support the growth of any and all pathogens not only from spinal fluid but from any other specimen submitted for culture.[3] Differential, selective media of special formulations are available from several different commercial sources ranging from the dehydrated granular or powder form to that which is prepared in sterile tubes or Petri dishes. The ready availability of excellent bacteriologic media makes it almost criminal for a laboratory not to provide proper cultures of spinal fluid sediment. At the risk of belaboring the point there are also available dehydrated media in tablet form; these tablets need only to be added to a culture tube or flask with distilled water, sterilized in the autoclave, allowed to cool either in the tube or poured into a sterile Petri dish before use.

Four Media Used

It should be possible for practically every laboratory to have available four different types of media to be used in culturing spinal fluid for pathogenic bacteria other than the tubercle bacillus. These media are: blood agar, chocolate agar fortified with a nutritional yeast concentrate supplement, trypticase soy broth or

brain heart infusion broth and thioglycollate broth.

(It should be noted that human blood is the least desirable for the blood agar medium due to the antibody content and high levels of citrate and glucose in blood drawn for transfusion. Defibrinated sheep, rabbit, or horse blood is the blood of choice and should be used for maximum results.)

Four Media

The selection of these four media is to a degree an arbitrary one since there are other media that will accomplish the same purpose. The objective is to provide an adequate but not superfluous battery of artificial media that will support the growth of any bacterium or fungus that might be present in the spinal fluid. Thus *H. influenzae, N. meningititidis, D. pneumoniae, Staph. aureus,* streptococci, (including the viridans, pyogenes, and enterococcus groups), all of the *Enterobacteriaceae* (*E. coli, Salmonella, Proteus, Klebsiella,* etc.), *Pseudomonas aeruginosa,* and many of the "miscellaneous" or less frequently isolated bacteria as well as pathogenic fungi will grow on one or more of the four media recommended.

The agar plates are streaked with the sediment and the broths are inoculated with a loop full of the sediment. All media are incubated at 36 to 37° C. and the chocolate agar plate is placed in the "CO_2 jar" in an atmosphere of 5% to 10% CO_2. This is provided by the customary candle or a more elaborate procedure where CO_2 is generated by the reaction of dilute H_2SO_4 and Na_2CO_3 added to a small container in the jar or by admitting a measured amount of CO_2 from a tank which can be attached to an inlet of the jar.

The often stated "anerobic" incubation in reference to the CO_2 jar[17, 22] is incorrect since what is really achieved is an increased tension of CO_2 and not the exclusion of all the oxygen. However, should an anerobic environment actually be required for the growth of the organisms present in the spinal fluid it is provided by the thioglycollate broth which will support the growth of most anerobes.

Continue Incubation Four Days

Incubation is continued for at least four days with daily observation. Growth in any one of the cultures must be subjected to whatever diagnostic bacteriological screening procedures are necessary to establish the identity of the organisms. A responsible, well trained microbiologist is aware of the necessity for accurate and expedient identification of the organisms isolated and the procedures required to identify the organism(s) are directed toward this goal. This identification in most instances is a confirmatory one since a presumptive identification may have been made from the examination of the Gram stained smear.

In any event the identification must be as definitive as possible. This involves morphologic study of the colonies and microscopic examination of stained smears to establish the bacterial cell morphology and to indicate what additional tests are required. These additional tests may be quite simple such as the test for bile solubility and optochin sensitivity[5] to distinguish pneumococci from alpha hemolytic streptococci or the identification may be more involved and require several biochemical determinations plus an antigenic analysis as is the case when a *Salmonella* species is isolated.

In an epidemic caused by the pneumococcus or meningococcus it is possible to identify the specific antigenic type responsible by capsular swelling tests using appropriate antisera. It is also necessary for the clinician as well as the microbiologist to be aware of the increasing incidence of meningitis caused by *Listeria monocytogenes*[2, 10], *Flavobacterium*[9], *Leptospira*[4] and other organisms. Awareness of the possibility of these organisms greatly facilitates their identification.

Determine Antimicrobial Agents

While the identification procedures are being carried out it is also desirable to determine the antimicrobial agents to which the organism is susceptible or resistant. Even though well accepted therapeutic regimens have been established for the majority of the bacterial meningitides, antimicrobial susceptibility tests should be performed to detect the possible resistant strains to the drug of choice or to assure the clinician that his choice of drug for therapy is substantiated by *in vitro* tests.

If a fungus infection is suspected either on a clinical basis or after examination of wet mounts or stained smears, duplicate plates of blood agar and chocolate agar along with a plate of Sabouraud's agar and Eugon agar or Mycosel agar should be inoculated and incu-

bated at room temperature. Incubation is maintained for three to four weeks and observed twice weekly.

The fungi responsible for meningitis in man are predominantly of the spherical or "yeast-like" morphologic type. These include *Cryptococcus neoformans, Candida albicans, Coccidioides immitis, Blastomyces dermatitidis,* and *Histoplasma capsulatum*. Each of these can be identified by careful microscopic examination of KOH or methylene blue wet mounts prepared from the growth obtained at 37°C. and at room temperature. *B. dermatitidis, C. immitis,* and *H. capsulatum* are diphasic fungi producing a characteristic "yeast-like" growth at 37°C. and an equally characteristic mycelial growth at room temperature. *Cryptococcus neoformans* produces encapsulated yeast-like cells at both 37°C. and room temperature. *Candida albicans* produces mycelia and yeast-like cells at both temperatures. All of these fungi possess several other points of morphologic distinction as well as certain biochemical tests which are helpful in their identification.

Tuberculous Meningitis

When tuberculous meningitis is suspected, smears of the centrifuged spinal fluid sediment or pellicle should be stained by an acid fast technique and then carefully examined microscopically. Despite the fact that acid fast bacilli are infrequently found in smears, those instances in which they are found make the effort worth-while as the clinician can proceed with a reasonable assurance that a correct diagnosis has been made.

The spinal fluid sediment should be cultured for *Mycobacterim tuberculosis* for positive confirmation of the diagnosis. At least a dozen acceptable media are available and the selection is largely a matter of choice based on the personal experience of the microbiologist. Good results have been obtained with all.

There is however close agreement that at least two, and preferably three, different media should be employed. The three best are ATS medium (American Trudeau Society), Dubos-Middlebrook oleic agar medium, and Lowenstein-Jensen medium. Each of these is inoculated with two loop fulls of the sediment resuspended in a small amount of the spinal fluid and all media are incubated at 35-37°C. for eight weeks.

These cultures should be carefully examined at weekly intervals and any growth should be promptly examined by appropriately stained smears and other tests necessary to confirm the presence of the tubercle bacillus. Frequently the growth may be very scant with only one or two cream-colored or buff white colonies present. Subcultures may be required in order to obtain sufficient growth for the niacin test,[13, 18, 20] neutral red test,[8, 11] or guinea pig pathogenicity test to establish the growth as *Myco. tuberculosis.*

The distinction between the human and bovine varieties can be made if necessary by the niacin test. The human tubercle bacillus will give a positive niacin test[16, 21] while the bovine variety will give a negative niacin test. The isolation of the "unclassified" or "anonymous" acid fast bacilli from spinal fluid has not been reported and apparently they are of no great concern as a cause of human meningitis.

Summary

Despite the fact that several types of purulent meningitis may present a clinical picture which is often diagnostic no acceptable proof can be made unless the causative organism is isolated and identified. In order to achieve this end it is necessary for the clinician to perform the lumbar puncture as part of his examination of the patient. Since the spinal fluid provides the best means of establishing the etiologic diagnosis, it must be examined promptly in a competent fashion so that the offending agent may be identified without delay. A brief statement of the clinical impression will enable the microbiologist to provide maximum diagnostic assistance to the referring physician.

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Diagnostic Difficulties in Bacterial Endocarditis

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IN FEW diseases have the natural history, incidence and mortality been so decidedly altered as in bacterial endocarditis since the introduction of antibiotics. It is now almost 20 years since Loewe first employed penicillin in its treatment.[1] In place of the invariably fatal course of the pre-antibiotic era, we may now expect a cure rate of 50% to 75% under ideal conditions of diagnosis and treatment.[2, 3, 4, 5] Previously a disease of the consultant, the classical picture is now widely recognized and treatment is frequently undertaken by the general physician.

Still Has Residual Mortality

Despite these changes bacterial endocarditis still has a respectable residual mortality, depending upon the nature of the infecting organism, the degree of valvular damage produced and the presence of embolic, cardiac and renal complications. These sequelae of endocardial infection bear a direct relationship to the duration of the disease so that early diagnosis is crucial to forestall their appearance. Even in those patients in whom infection can be controlled, about one-third succumb to the late effects of the infection on the heart valves and myocardium. Missed or delayed diagnoses contribute significantly to this residual mortality as much as inadequate or ineffective treatment schedules. Indeed the very effectiveness of antibiotic therapy has engendered an unfortunate attitude of security which is unwarranted in the face of the grave consequences of a therapeutic or diagnostic misstep.

Several recent reviews have emphasized the fact that one of the major impediments to early diagnosis is the infrequency of the complete classical clinical picture in patients with endocarditis.[3, 4, 6, 7] The purpose of the present essay is to review some of the diagnostic difficulties emphasized in these reviews and in the author's own experience.

Space does not permit a discussion of the details of management. Excellent reviews are available which outline the preferred treatment for each of the usual infecting organisms.[4, 6, 7] Every physician essaying to treat this disease should familiarize himself with these details.

In this essay the term bacterial endocarditis will be used to cover both the acute and subacute forms of this disease. The former distinction between the two was based on the severity of the clinical picture, the type of infecting organism and whether or not the infection was engrafted upon a normal valve. These distinctions are now known to be invalid since there is considerable overlap in these features in the two forms. It is preferable to think of infectious endocarditis as a spectrum ranging from the very acute disorder, death possible in a few weeks, to a very protracted one, lasting a year or more. The degree of destruction of the invaded valve and the presence of myocarditis or embolic phenomena usually dictate the rapidity with which the disease progresses.

Clinical Manifestations

The clinical manifestations of bacterial endocarditis became fairly well crystallized in the early decades of this century following the observations of some of the outstanding clinicians of the time. The names of Osler, Libman, Horder and Schottmuller[7] are associated with the emergence of what is now known as the "classical" clinical picture. This is characterized by fever, murmurs, petechiae, embolic phenomena, splenomegaly, clubbing, anemia,

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azotemia and almost invariable fatality. This complex of signs has so dominated the thinking of clinicians that the diagnosis of bacterial endocarditis is still missed or delayed awaiting its full development.

The minimum requirements dictating treatment are in actuality much fewer. Tumulty[3, 6, 7, 8] and others have clearly demonstrated that the classical findings are absent in 50% or more of patients on admission to the hospital. In one report of 148 patients, ". . . 74% had no evidence of embolization on admission, 60% had no petechiae, 61% had no splenomegaly, 88% had no clubbing of the fingers."[4] These are a function of the duration of the disease and even when present may not be at all specific. Petechiae and splinter hemorrhages, for example, may be seen in rheumatic fever or in bacteremia without endocarditis.

Early Diagnosis

Early diagnosis is therefore dependent upon a high degree of suspicion of this disease in any patient with the combination of fever with a murmur or with known congenital or rheumatic heart disease. Any combination of the "classical findings" with or without fever in such a patient should lead to blood culture. Likewise, the development of a murmur in a patient with bacteremia should be tantamount to a diagnosis of endocarditis.

The early symptoms of endocarditis are rarely helpful because of their nonspecificity and the relative paucity of accompanying physical signs. Malaise, headache, joint aching or swelling, a "flu" like syndrome, muscle pains, sweating and chilly sensations are easily dismissed. They should immediately alert the sensitized clinician if they occur in certain contexts—in a patient with a murmur or with a history of rheumatic or congenital heart disease, or following dental extractions or manipulations, or in a drug addict, or in a patient with hereditary tenalgiectasis and pulmonary A-V fistula as examples. It is now known that Streptococcus viridans endocarditis can occur in the edentulous patient. While infrequent, endocarditis occurs in the patient with atrial fibrillation as well as in those with regular sinus rhythm. There are no rules which help to exclude the diagnosis completely.

The signs and symptoms of heart disease are often minimal. While a murmur is present in the majority of cases, it may be quite unimpressive, especially in the aged. In those patients without a murmur at the outset, one usually appears during the course of treatment.[10a] However, it has been recognized for some time that the murmur may be absent throughout the course in a small number of cases.[11] Vogler[4] et al recently reported complete absence of murmurs in six patients out of a total of 148 with endocarditis. Significantly, five of these patients came to autopsy. We have recently observed a patient who had bacterial endocarditis for a period of six months but failed to detect a murmur during or after treatment. The absence of a murmur may occur when the endocardial infection is engrafted on a bicuspid aortic valve, the right side of the heart or very rarely on a mural thrombus.

Changing Murmurs

Changing murmurs are still too often cited as a diagnostic criterion of bacterial endocarditis. Recognizable variations in intensity and pitch may occur on serial auscultation in any murmur but this is certainly not specific for endocarditis. If there is a really marked change in the character of a murmur, one has already probably waited too long to make the diagnosis for this usually signals ulceration or perforation of a valve cusp or rupture of one of the chordae tendinae.

The fever in endocarditis has no distinguishing characteristics. It can range from near normal to 105° and may be spiking, continuous, remittent or intermittent. It is essential to ascertain the cause of fever in any patient with a murmur. Such a patient with fever of even a few days' duration should be considered to have endocarditis until otherwise proven.

One very effective way to make the diagnosis more difficult or even impossible is to institute treatment with a bacteriostatic agent for a fever whose cause is obscure. Resolution of fever and negative blood cultures will often result temporarily but the infection will continue to produce damage to heart valves or myocardium. The first step, if the history is in any way suggestive, is to stop all antibiotics, antipyretics and steroids. The patient should be observed for a return of fever, obtaining serial

blood cultures in the interim. If a murmur develops de novo in a patient with a fever then it is almost certain that endocarditis is present.

Fever, too, may be absent throughout the entire course of endocarditis in a small number of patients and it therefore cannot be relied upon as a sine qua non of the disease.[4]

Blood Culture

The blood culture properly taken and carefully done is the most useful of diagnostic tests. Almost every clinical laboratory performs blood cultures but few do them adequately. Delayed isolation and identification of the infecting organisms is a significant factor in obfuscating the diagnosis. In the most expert hands, from 10% to 20% of cultures may be negative.[5] In the average laboratory it is to be expected that the percentage might be higher. Negative cultures in a clinical context suggesting endocarditis should raise the possibility of a right-sided lesion,[12] recent inadequate but suppressive antibiotic treatment or an unusual organism like a fungus or anaerobe.

The bacteremia of endocarditis is a steady and not an intermittent phenomenon.[13] There does not appear to be evidence for an optimal time for taking cultures.[14] The majority of positive cultures are obtained within the first three days and very few additional ones thereafter.[5] Valuable time should not be lost awaiting the appearance of positive cultures beyond four or five days, therefore. There is no evidence to support the still prevalent notion that positive cultures can more frequently be obtained from arterial blood. Occasionally, bone marrow cultures will be positive when venous blood is not. One or two positive cultures out of a group of negative ones should be accepted with caution.

Isolation of the usual infecting organisms—streptococci, staphylococci and enterococci—is usually accomplished by inoculation of broth media such as trypticase soy or brain-heart infusion. Pour plates are useful and recommended—0.5 and 1.0 ml. of the patient's blood mixed with suitable agar medium and evenly distributed over the bottom of a sterile petri dish. Cultures should be kept for four weeks since some organisms like bacteroides and some streptococci may be slow growing. Anaerobic cultures should be obtained if bacteroides are suspected. Fungi should be looked for if ordinary cultures are negative. It is wise to enlist the aid of the bacteriologist early and acquaint him with the clinical findings and the type of organism expected.

Type of Organism and Clinical Picture

One may suspect the nature of the infecting organism from the clinical context although the clinical picture varies little with different organisms. In general, the streptococci will be found in the usual case with underlying congenital or rheumatic heart disease. The enterococci or members of the coliform group occur where there is GU or GI infection or manipulation. They are common in older men and in women following abortion. The staphylococci are usually associated with an infection elsewhere in the body, like a furuncle and are more likely to be found if the patient has had no previous heart disease. They are common, too, in post-cardiotomy infections. Candida albicans should be suspected where there is an indwelling needle or catheter or when the patient has been on long term antibiotics, ACTH or adrenal steroids.[15]

In those patients in whom negative cultures are obtained in the face of a suggestive clinical picture, treatment should be instituted on the basis of a prudent guess about the nature of the infecting organism.

The focal point of management is the choice of the right antibiotic or combination of antibiotics in adequate dosage. Sensitivity tests provide the best means of arriving at such information. They must be used with discrimination and awareness of their limitations as pointed out by Finland.[9]

Avoid Precipitate Treatment

Delay in treatment may be costly but precipitate treatment may be worse. Rarely is the situation so threatening that two or three days cannot be spent in obtaining four to six blood cultures. If these are negative, treatment should be initiated whenever the clinical situation is at all suspicious of endocarditis. This should not be used as an excuse, however, for inadequate bacteriology. To undertake treatment without identification of the organism is like setting sail on a dark night without a compass. When nec-

essary, it must be done but not before a genuine attempt at bacteriological diagnosis has been made. Otherwise treatment will of necessity be empirical and largely based on guesswork as will the assessment of results. Valuable time will be lost retracing one's steps through a maze of antibiotics to pick up the trail of the infecting organism.

The usual laboratory tests are of little value in supporting a suspicion of bacterial endocarditis. The leucocyte and differential counts are rarely distinctive. Anemia and hematuria are more a function of the duration of the disease and should not be waited for. Anemia occurs earlier in endocarditis in which there is early and severe valve destruction; hyperglobulinemia is common and may produce altered cephalin flocculation and other flocculation tests. These are rarely helpful though they might suggest this disease if no liver disease is present.

Many authors have commented on the finding of actively phagocytic histiocytes in the first drop or two of blood from the ear lobe. These cells are found usually at the periphery of the bloodsmear. They are indicative of the reticuloendothelial system's response in endocarditis and can be helpful in suggesting the diagnosis if leukemia and other blood dyscrasias can be excluded.[15a] We found this examination useful in a recent case in which phagocytic histiocytes were obtained in the skin biopsy from a patient with one of the cutaneous manifestations of the disease—the "placards erythemateux douloureaux" described by Debre.[16]

The Elderly Patient

In our experience, the most difficult diagnostic situation is that of the elderly patient in whom slight fever, anemia, cerebral embolization and a systolic murmur may be attributed to the diseases of old age. One's suspicion cannot be too great in an elderly patient who presents with a "stroke" in any way atypical, anemia, uremia, meningitis or repeated embolic phenomena.[17] "Nephritis" is often misdiagnosed for endocarditis and should alert the clinician to the possibility of endocarditis if it occurs in the aged patient.

For these reasons a larger number of fatalities due to endocarditis is now to be found in the older age groups as contrasted with the pre-antibiotic experience.[2] The growing number of the aged and the longer life of patients with heart disease will make this a continuing problem for all clinicians. One can only hope that the freer use of blood cultures in the aged will help in establishing this diagnosis more frequently.

Several other situations introduce factors which further complicate early diagnosis. Right-sided endocarditis is notoriously difficult to detect. Murmurs are usually faint or absent and there is a paucity of embolic manifestations.[12] Pneumococcal meningitis may be associated with endocarditis which is overshadowed by the meningeal infection but which later manifests itself in a perforated valve with rapid onset of heart failure. Post-cardiotomy endocarditis—usually the result of staphylococcal infection—may also be hard to discern. The only sign may be fever.[18]

The importance of early diagnosis in bacterial endocarditis can hardly be overemphasized. Even when it is made early and an adequate treatment instituted about one-third of the patients succumb to late complications of the disease. In the pre-antibiotic period the major cause of death was uncontrolled infection, heart failure and renal failure. The major cause in treated cases is valve perforation which has increased from 15.6% in the pre-antibiotic period to 44.5%. The majority of the latter patients have congestive heart failure.[19]

Summary

The use of antibiotics has greatly diminished the mortality of bacterial endocarditis. The residual mortality is attributable largely to infection with resistant organisms, to the late effects of valve perforation, to embolic phenomena and to myocardial damage. Delayed or missed diagnosis occurs with unfortunate frequency even in institutions alerted to this disease and the varying modalities of its clinical presentation.[19]

Until more effective antibiotics are available for the treatment of the staphylococci and other resistant micro-organisms, this residuum of mortality will not be eliminated entirely. However, there are measures under the control of every clinician which can materially influence the outcome. These are: Prevention of rheumatic fever, proper prophylaxis for all patients

with valvular heart disease or murmurs, undergoing surgical or dental manipulation and, most of all, early diagnosis and adequate treatment.

Prompt diagnosis is therefore a grave responsibility for every physician. The complete "classical" syndrome cannot be expected except in a minority of cases. The more subtle manifestations of the disease and the modulations of its natural history must be more widely known.

Every physician must be "sensitized" to the many variations from the standard clinical picture and to the difficulties in early diagnosis. Only then can the damage to heart valves and myocardium which account for most of the mortality in the bacteriologically cured patient be prevented.

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Remember!

DIABETES DETECTION WEEK

November 11-17

Prophylactic Antimicrobial Therapy

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THE nonspecific prophylactic use of antimicrobial and chemotherapeutic drugs is not only ineffective in most instances but often injurious. These agents are used by physicians in almost every branch of medicine, and yet knowledge of their indications and contraindications is often lacking or ignored.

In recent years it has become "routine" for many physicians to "cover" almost any seriously ill or potentially infected patient with an "umbrella of antibiotics," and, as Finland has said, one might justify the use of antibiotics in a single individual "from the Womb to the Tomb." This report deals with a limited number of situations where adequate studies are available to permit an intelligent decision as to whether or not to use antibiotics prophylactically.

Situations Where Prophylaxis Has Been Found Useful

The use of a sulfonamide or penicillin in preventing recurrent attacks of rheumatic fever has been studied for 20 years and has been found to decrease recurrence rates of this disease by 85% to 90%. Penicillin has generally replaced sulfonamides, and in those patients sensitive to penicillin, erythromycin or a tetracycline may be used. It is recommended that all patients who have had rheumatic fever receive penicillin 250,000 units orally b.i.d., or benzathine penicillin 600,000 units intramuscularly monthly for at least five years, and some investigators believe prophylaxis should continue indefinitely.

A similar case can be made for acute glomerulonephritis, but this is less well documented. There are 40 different types of Group A beta hemolytic streptococci, but only four of these (types 12, 4, 19, and 25) have been found associated with glomerulonephritis. It has been recommended that patients with acute glomerulonephritis receive penicillin prophylaxis for at least six months after the attack, and that family carriers should be treated with a 10-day course of penicillin. To date, no penicillin resistant beta streptococci have been found.

Most investigators feel that patients with rheumatic or congenital heart disease should receive penicillin prophylaxis prior to dental or urologic surgery. The evidence that this is actually effective would take years to accumulate because of the few (one in 533) susceptible individuals who actually develop subacute bacterial endocarditis (SBE) under these circumstances.

Finland recommends 600,000 units of procaine penicillin and 200,000 units of aqueous penicillin intramuscularly for these patients before surgery. Cardiac surgery is a new source of SBE and penicillin and streptomycin have been advocated in patients with rheumatic heart disease or congenital heart disease undergoing surgery. The actual incidence of SBE among these patients is low (circa 1%), but the mortality may approach 60% and the bacteria are usually resistant to the common antibiotics.

Prophylactic antibiotics have been advocated in women with rheumatic or congenital heart disease before and after delivery, but data are not yet available to evaluate such therapy.

Experience during World War II proved that outbreaks of meningococcal meningitis could be aborted by the vigorous treatment of sporadic cases with sulfadiazine and prophylaxis (2 Gm./day) among close contacts. It was also found that gonorrhea could be prevented by a single tablet of 250,000 units of penicillin taken 3-4 hours after exposure; the schedule for prostitutes being 2.4 million units of benzathine

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penicillin each month. No gonococci have been found which were highly resistant to penicillin. In preventing syphilis a full therapeutic course of penicillin is necessary, and it is probably better to wait for evidence of clinical infection or a positive serology before treating. Congenital syphilis is absolutely prevented by early adequate treatment of the infected mother.

In diarrhea of the newborn where, if one case occurs, the disease may spread rapidly through a nursery, intensive efforts have been made to use antibiotics effectively. Unfortunately the organisms involved have developed resistance quickly and early success is frequently followed by development of resistant strains and complicating staphylococcal infection.

In bacillary dysentery, many prefer small doses of a tetracycline in the uninfected. When E. coli is responsible, probably *all* children in the nursery should receive neomycin and polymyxin; cultures should be repeated frequently to ascertain the development of resistance or change in flora. Antibiotics alone will not prevent the occurrence or the spread of these infections and too much importance cannot be placed on cleanliness, isolation techniques and eliminating carriers of pathogenic organisms from the nursery area.

Pulmonary mucoviscidosis (pancreatic fibrosis) is almost always accompanied by pulmonary infection and antibiotics have been shown to prolong life in these children. Continued use of small doses of tetracycline are recommended, but patients must be watched for complicating staphylococcal and fungal infections. The English have found prolonged therapy with small doses of broad spectrum antibiotics to be useful in patients with chronic bronchitis and asthma, but investigators in this country are divided on this subject.

The use of penicillin, when combined with early debridement, has been found useful and indicated in massive, contaminated wounds, such as battlefield injuries where the incidence of gas gangrene was found to have decreased from 5% in World War I to less than 0.1% in the Korean conflict. It is also indicated in severe dog bites because it easily eliminates the Pasteurella septica which frequently contaminates these wounds.

Preparation for surgery on the large bowel now routinely includes the use of antibiotics. Neomycin is frequently used and most investigators believe this or similar agents are necessary; however, some surgeons have recently abandoned the practice and cast doubt on the necessity for its use. In small bowel obstruction antibacterial agents are definitely helpful, but cultures should be taken at the time of surgery to assist in choosing the proper agents for postoperative use.

When operating through an infected field in many areas of the body, the use of antibiotics may be justified, but this should be considered therapeutic rather than prophylactic and every effort should be made to identify the organism and use a specific antibiotic directed at that organism.

In the case of thoracic surgery for tuberculosis, anti-TB drugs should be continued for six months after surgery. In brain surgery and arterial surgery (particularly where prostheses are used) prophylactic antibiotics are routinely employed, but no evidence exists that their use changes the outcome in these patients. It has been suggested that topical agents, such as bacitracin, may be of more value in these cases, and less of a hazard.

Conditions Where Prophylaxis Has Not Been Found Useful

Probably the greatest value of the studies which have been done on the prophylactic use of antibiotics has been to point out the inherent futility and, frequently, the unfortunate consequences of their indiscriminate use. In many circumstances where logic might lead one to use an antibiotic prophylactically, experience has shown that they may not be indicated and actually may be hazardous. The most obvious example of this is in the routine use of penicillin and/or streptomycin in the pre- and postoperative patient.

All recent studies on this have shown that the incidence of wound and other complicating infection is definitely not lessened and actually may be increased significantly by using these agents. When infection does occur under this "umbrella" it is almost invariably due to a resistant organism, most often hemolytic staphylococcus aureus. Finland has stated that most good surgeons have abandoned the use of routine postoperative antibiotics. I am not sure that this is true in this part of the country.

Considerable literature exists on this subject

and I will mention only a few studies. In 1954 McKittrick and Wheelock reviewed the complications of elective gall bladder and bile duct surgery at the Massachusetts General Hospital since the introduction of antibiotics and found the incidence of postoperative infection not reduced by prophylactic agents. Barnes reviewed 1,947 herniorrhaphies at the Massachusetts General Hospital and 5,000 hysterectomies and found the same results. Linder, in 1957, found wound infection and pulmonary complications slightly higher in prophylactically treated patients who had undergone gastric surgery in Germany.

Howe, in 1956, found a steady rise in the incidence of wound infection at the Massachusetts Memorial Hospital up to 1954 and a sharp decrease after improving sterile technique and abolishing the use of prophylactic antibiotics. Tachdjian and Compere reviewed 3,000 clean orthopedic surgical cases and found a slight increase in postoperative wound infection in patients receiving prophylactic antibiotics and that those who developed wound infection while not on prophylaxis were easily treated, whereas the others were stubbornly resistant to treatment.

Many other investigators have found a rise in the incidence of wound infection in individual hospitals where routine prophylaxis has been practiced and, in particular, a rise in resistant staphylococcal infections. Most of these investigators have also found a rapid fall in the incidence and severity of infection when antibiotics have been reserved for the treatment of specific infections.

These same results have been found in studying cases of surgery on the chest and lungs, oral cavity, urinary tract and anorectal region. One thoracic surgery unit had to be closed because of the high rate of staphylococcal infections after routine use of pre- and postoperative antibiotics. Upon reopening this service and eliminating "routine" antibiotics the incidence of complicating infections dropped sharply.

In large studies performed at Brooke Army Hospital and at the Burns Unit of the Birmingham Accident Hospital in England, systemic antibiotics, and in most cases local antibiotics, were of no help in preventing infection in seriously burned patients and their use frequently led to development of resistant infections. Similar results have been found repeatedly in routine prophylaxis of patients with indwelling catheters. Frequent cultures and subsequent treatment of specific infections has been the only method effective in combating infection in these situations.

The results of efforts to prevent infection in medical patients are very similar to those in surgical patients. It is well known that patients with coma, shock, strokes, congestive heart failure, influenza, the common cold, measles, tracheotomy, and patients who are treated with steroids or x-ray, are unusually susceptible to infection. Attempts to decrease the incidence of secondary infection by the use of antibiotics in these patients have failed. More often than not, these efforts have led to the appearance of infection with staphylococcus, proteus, coliform or other resistant organisms in patients who otherwise, if infected, would most likely have had an easily treated pneumococcus, streptococcus or even a sensitive staphylococcus.

The routine use of prophylactic agents in medical, surgical, obstetrical and pediatric patients has led to increasing prevalence of resistant strains of organisms (especially the staphylococcus) in hospital populations and also of carriers of these organisms. Parenteral antibiotics are not effective in reducing carrier status, but local nasal ointments have helped, when combined with improvement in housekeeping, isolation and sterile technique.

Summary

Antibiotics, used prophylactically, are indicated in certain situations where one is attempting to prevent a specific infection with a known organism; when exposure to that organism is likely and where the organism is known to not develop antibiotic resistance readily. Examples of this are in the prevention of recurrent attacks of rheumatic fever and in preventing meningococcal infection in exposed individuals. In certain other areas experience has shown these agents to be useful prophylactically, even though one is attempting to prevent possible infection by a multitude of organisms, e.g., mucoviscidosis and massively contaminated wounds.

The prophylactic use of antibiotics has failed to reduce the incidence of complicating infection in most instances where the patient's susceptibility to infection is great but where exposure is present to a multitude of possible

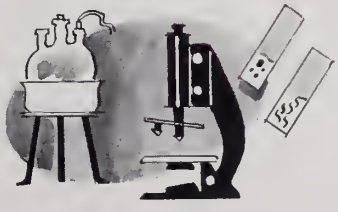
pathogenic bacteria. This lack of effectiveness has been well documented where it has been used routinely in postoperative patients and patients with debility, coma, congestive failure, viral infection, burns and in patients with tracheotomies or indwelling catheters.

Where "routine" prophylactic use of antibacterial agents has been the practice, the incidence of complicating infection has remained the same, or actually increased, and the easily treated complicating infections are found to be quickly replaced by antibiotic resistant infections. The increasing problem of staphylococcal infection and carrier status, and the increasing incidence of clincial infection with resistant gram negative organisms has been most troublesome where the general concept of "covering the patient with an umbrella of antibiotics" has been the rule. Conversely, where antibiotics have been reserved for specific indications, a drop in complicating infection and particularly, in resistant infection has been observed.

The cost and toxicity of the antibiotics should be additional incentive for physicians not to make the use of these agents "routine" under any circumstances.

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Staphylococcal Infections

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APPROXIMATELY 10 years ago antibiotics were first introduced into clinical medicine. At that time pneumococci, Group A beta-hemolytic streptococci and coagulase-positive staphylococci were the predominant gram-positive organisms responsible for human disease, and all three of these bacteria were highly susceptible to penicillin G in very low concentrations.

All pneumococci and Group A beta-hemolytic streptococci have remained susceptible to penicillin G and none of the newer antimicrobial agents is more effective against these two groups of bacteria. However, very soon after penicillin G was readily available, a few strains were discovered which produced an enzyme penicillinase and which were, by this means, resistant to penicillin G. Penicillinase-producing staphylococci very quickly became the predominant type of staphylococci within hospitals.

More Recent Antibiotics

A similar process has occurred with many of the more recently introduced antibiotics so that there are now present in most hospital environments a large reservoir of staphylococci which are resistant to penicillin G, tetracycline, erythromycin and chloramphenicol and which have been named "hospital staphylococci."

These staphylococci are now one of the more difficult infections to treat and, together with pseudomonas, proteus and other gram-negative bacteria which are also resistant to many antimicrobial drugs, are responsible for most of the problem cases in infectious diseases.

During the past few years, a large number of investigators have studied the epidemiology, immunology and host response of the staphylococcus, and a number of new drugs have been discovered which are specifically active against staphylococci resistant to other antimicrobial agents. Although a large number of very important questions remain to be answered before completely effective control can exist, there is now sufficient information to outline general principles required to minimize infections due to this organism.

Epidemiology of Hospital-Acquired Infections

The number of potential sources of virulent coagulase-positive staphylococci within hospitals is extremely large. These bacteria can be cultured from walls, floors, air, bedding and clothing of almost all areas in contact with patients or personnel. Generally staphylococci do not multiply here, and if further exposure to human sources is prevented, the organisms gradually disappear. One of the classical means of controlling epidemics has been to close the nursery or ward affected. When the closed areas are again used for patient care, the staphylococci present on inanimate objects usually do not cause further outbreaks.

However, in wounds or lesions and in various sites on carriers without infections, large numbers of staphylococci are present, and these organisms multiply and may be continuously disseminated into the environment where they are available to infect susceptible individuals.

Lesions are obvious sources of staphylococci which have proven their virulence, and it is generally agreed that patients with staphylococcal lesions should be effectively isolated from other patients and personnel. Carriers are not as easily detected and because of their large number it is not possible to isolate all carriers or to

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remove them from contact with susceptible patients.

At the Louisville General Hospital[1] approximately one-third of all adult patients and personnel are nasal carriers of coagulase-positive staphylococci which are potentially virulent by the usual laboratory tests. Approximately half of the staphylococci isolated from these carriers were resistant to both penicillin and tetracycline, and one-fourth were also resistant either to chloramphenicol or erythromycin or both of these drugs. Therefore, one-sixth of all patients and personnel are potential sources of multiple drug-resistant staphylococci and one patient out of every eight is a carrier of a staphylococcus which is resistant to at least three of the four commonly used antistaphylococcal drugs.

Not all carriers disseminate these organisms diffusely and attempts have been made to further identify "dangerous" carriers who have also been called disseminators or "cloud" babies.

Dangerous Carriers

Initially, dangerous carriers were identified by the outbreaks of staphylococcal disease which occurred in their environment.[2, 3] The staphylococci isolated from lesions were of the same phage type and susceptible to the same antibiotics as staphylococci isolated from dangerous carriers. Also, removal of the carrier was followed by a decrease in staphylococcal disease in the affected area.

More recently, Eichenwald and co-workers[4] have shown that certain infants who were nasal carriers of coagulase-positive staphylococci disseminated their organisms into the air in much larger numbers than other infants who were also carriers. The disseminators or "cloud" babies were frequently also infected with known respiratory viruses, and these investigators postulated that by some means viral infections in infants converted nasal carriers of staphylococci, who did not disseminate staphylococci into the environment, into disseminators or "cloud" babies.

It has also been shown that the number of staphylococci which can be isolated from adult carriers varies from only a few colonies to over 1,000,000 colonies per culture.[5] In addition, nasal carriers of large numbers of staphylococci disseminated their organisms into the air and onto the skin more frequently and in larger numbers than either nasal carriers of smaller numbers of staphylococci or patients who were not carriers. Suppression of nasal staphylococci by topical antibiotics was followed by a marked reduction in aerial dissemination and in the number of staphylococci on the skin.[6] These studies suggest that only the one-third of carriers who carry large numbers of these bacteria are dangerous to other patients in initiating staphylococcal disease.

Treatment with Antibiotics

Although temporary suppression of nasal staphylococci occurs during treatment with antibiotics such as methicillin (Staphcillin®) or oxacillin (Prostaphlin®) to which there are, at present, no available resistant strains of staphylococci,[7, 8] most carriers reacquire these bacteria when treatment is discontinued.

When carriers are treated with penicillin G, tetracycline, erythromycin or chloramphenicol to which a large proportion of staphylococci are resistant, the susceptible staphylococci present in the nose are eliminated but are rapidly replaced during treatment with staphylococci which are resistant to at least the administered drug.[9] By this means, patients who are carriers of staphylococci and who receive antibiotics for pneumococcal pneumonia, pyelonephritis or other diseases serve as reservoirs for multiplication and further dissemination of resistant staphylococci. By rigidly restricting the use of antibiotics in one hospital,[10] the proportion of staphylococci from infections which were resistant to antibiotics was markedly reduced.

In contrast to the ease with which sensitive staphylococci in carriers are replaced with resistant organisms, the staphylococci isolated from established lesions usually do not change their antimicrobial susceptibility during treatment and such sources are not of major imporance in increasing the resistance of staphylococci within a hospital.

Exposure to Staphylococci

Although all hospitalized patients are exposed to staphylococci, only a few patients acquire staphylococcal disease. In certain situations in which the normal host defense is impaired, greater precautions must be taken to reduce to a minimum the individual exposure to

these organisms. Among the groups which are more susceptible to staphylococcal disease are infants and patients with influenza, burns, acute leukemia and surgical patients.[11, 12] In patients with influenza and acute leukemia, the risk of acquiring bacterial infections within the hospital should be seriously considered and balanced against possible benefits of hospitalization.

Within the past few years, a number of new antistaphylococcal agents have been introduced which are active against staphylococci which are resistant to penicillin G, tetracycline, erythromycin and chloramphenicol. The most promising of these are the synthetic penicillins. The basic nucleus of all the synthetic penicillins is 6-amino-penicillanic acid. A large number of penicillins have been synthesized by adding various side chains to this basic nucleus.

All of the highly active synthetic penicillins are highly resistant to staphylococcal penicillinase and are therefore active against both staphylococci which produce penicillinase and those which do not.[7, 13-15] They are, however, less active than penicillin G against staphylococci which do not produce penicillinase and also against pneumococci and Group A beta-hemolytic streptococci. For these reasons, they are intended only for staphylococcal infections which produce penicillinase and are resistant to penicillin G.

Naturally Resistant Strains

A few strains have been reported which are naturally resistant to methicillin (Staphcillin®)[16] and have almost complete cross-resistance to the other synthetic penicillins, oxacillin (Prostaphlin®)[17] and 6-(2-Ethoxy-l-naphthamido) Penicillanic Acid.[18]

Unless the use of these newer penicillins can be restricted to serious staphylococcal diseases resistant to other antibiotics, it seems likely that in the future our hospitals will have a reservoir of staphylococci resistant not only to penicillin G, erythromycin, tetracycline and chloramphenicol but also resistant to all three of the other synthetic penicillins as well.

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Intravenous Amphotericin B Therapy In Children With Histoplasmosis

JOSEPH A. LITTLE, M.D.*
Nashville, Tenn.

THE USE OF intravenous amphotericin B in the treatment of three infants and one older child with disseminated histoplasmosis was reported in 1959.[1] Since this time, five additional patients have received amphotericin B. Of these, three were infants with disseminated histoplasmosis and two were older children, one with "advancing" pulmonary disease and one with disseminated histoplasmosis.

Outline of Therapy

An initial dosage of 0.25 mg. per Kg. body weight was dissolved in 5% dextrose in water. The concentration never exceeded 10 mg. per 100 ml. solution. This was given at such a rate that the total dosage was infused over a six-hour period and required at least a total volume of 200 ml. The daily dose was increased by 0.1 mg. per Kg. body weight until a maximum of 1.0 mg. per Kg. body weight was reached. This dosage was continued daily until a satisfactory clinical response was observed and then was given every other day for a total of four weeks. A shorter course was given purposely to one patient.

Results of Therapy

The results of therapy in these nine patients have been gratifying and are summarized in Table I. Case 8 died after three days of therapy. Initially the patient exhibited marked thrombocytopenia and hypofibrinogenemia which are poor prognostic signs in disseminated histoplasmosis. Only 0.75 mg. per Kg. body weight was given in the short time he survived. Nevertheless, one must consider that intravenous amphotericin B therapy was a failure in this case.

Table I

Disseminated Histoplasmosis
I. V. Amphotericin Therapy

Case	Age	Marrow Culture	Ppt** Test	Length Rx	Results
1. CTH	4 mo.	Pos	Pos	28 days	Good
2. TGB	8 mo.	Pos	Pos	28 days	Good
3. TFB	5 mo.	Pos	not done	25 days	Good
4. LDI	3 yrs.	Neg	Pos	21 days	Good
5. CRW	1¾ yrs.	Neg	Pos	5 days	Good
6. KK	3 mo.	Pos	Pos	28 days	Good
7. SH	4½ yrs	Pos	not done	28 days	Good*
8. CJ	5 mo	Pos	not done	3 days	Died
9. KG	3 mo	Pos	not done	28 days	Good

*See text.
**Precipitin test in agar gel.

Dramatic improvement occurred in the five other infants with disseminated histoplasmosis. Three were afebrile after seven to ten days of therapy and in the other two daily febrile spikes coincided with the infusions. In all instances the liver and spleen were no longer palpable at the end of treatment. Case 4 was reported previously.[1]

Case five, a child of 1¾ years, was admitted to the hospital because of fever and hepatosplenomegaly with a presumptive diagnosis of histoplasmosis. Intravenous therapy with amphotericin B was begun. He seemingly responded well, but laboratory confirmation of the clinical impression was lacking. Therapy was discontinued after five days and consisted of a total of 2.75 mg. per Kg. His response was considered as fortuitous. Somewhat later his precipitin test in agar gel was repeated using a freshly-prepared antigen and was found to be positive. This same serum had been reported as negative

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earlier. Since he seemed clinically well, no further therapy was contemplated. The rapidity of his response would seem to indicate a causal relationship but must for the present remain speculative only.

Case seven was a 4½-year-old white girl who had been diagnosed as having acute lymphatic leukemia about six months previously. The diagnosis had been confirmed by bone marrow aspiration, and she had been treated with prednisolone and 6-mercaptopurine. No antibacterials were prescribed. She responded to this therapy and was considered to be in complete clinical and bone marrow remission.

Bouts of Fever

About three months following her initial discharge from the hospital, her pediatrician reported bouts of fever and hepatosplenomegaly. Considering this a clinical relapse of her leukemia, he again referred her to the hospital.

Physical examination revealed a chronically ill child whose liver was palpated 4 cm. below the right costal margin and spleen 2.5 cm. below the left costal margin. There was no significant lymph node enlargement. Her WBC count was 1,050 with no abnormal cells, and her hemoglobin 6.4 gm. %. She continued febrile, and a bone marrow examination was reported as showing evidence of disseminated granulomatous disease of marrow. Culture of this marrow grew out H. capsulatum.

She was treated successfully with amphotericin B. She then remained well for six months when, because of an enlarging cervical lymph node, she was hospitalized for the third time. Excision of this mass followed by pathological study of the excised specimen revealed this to be acute leukemia of the lymph node. No evidence of granulomatous disease was observed. She died at home without evidence that the histoplasma infection had recurred.

Toxic Reactions

No one who has used amphotericin B is unaware of the undesirable reactions. In children these are usually mild, being limited to febrile spikes of 104 to 106 degrees during intravenous therapy. In addition, all nine patients had albuminuria which cleared after cessation of therapy. There was no rise in N.P.N. In one patient serious reactions were associated with therapy. This occurred during the second infusion and resembled anaphylactoid shock. The patient became cyanotic; his pulse was thready and he was cold and clammy to touch. The infusion was discontinued and warm blankets were applied to the patient. The reaction lasted approximately 25 minutes. The following day an oral antihistamine was given, but the reaction recurred. Epinephrine in oil was given intramuscularly, and the antihistamine orally before the third infusion. The reactions did not recur; after the 12th day, these drugs were discontinued.

Summary

Experience with the use of amphotericin B in seriously ill infants and children with histoplasmosis has been reported. In six cases the bone marrow culture was positive; diagnosis was confirmed in the other two by a positive precipitin test in agar gel. One child, age five months, died after only three days of therapy with amphotericin B. This patient was admitted to the hospital in a very serious condition with thrombocytopenia and hypofibrinogenemia.

One child, age 4½ years, developed disseminated histoplasmosis while being treated with prednisolone and 6-mercaptopurine for acute leukemia. The fungus disease was eradicated, but the child died later with acute leukemia.

Conclusion

At present, in seriously ill children with disseminated histoplasmosis, therapy with intravenous amphotericin B gives very encouraging results.

(It is notable that two of the nine patients had some form of leukemia.—Ed.)

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Surgical Excision Metastatic Neoplasms of the Lung

Herbert T. Ransdell, Jr., M.D.*

METASTATIC tumor of the lung has previously been considered as evidence of hopeless cancer and the patients harboring such tumors so managed. Several case reports during the last 30 years and recent reviews of sizable series of these tumors indicate that many of these patients can be cured of their tumors by surgical excision of these lesions. The impression of a hopeless prognosis for many patients with these lesions should therefore be revised.

Case Report

This 12-year-old, white female was first seen in the emergency room of the Louisville General Hospital September 2, 1959, with complaints of "swelling" of her left leg and knee and pain of the knee on straining movements of the knee. Examination revealed no swelling or tenderness of the leg or knee; however, there was some slight discomfort when the knee joint was hyperextended. She was advised to use hot packs on the knee and to return in one week.

She did not return until November 9, 1959. She was then complaining of mild swelling, tenderness and pain of the left knee on walking, of five weeks' duration, following a fall when her knee suddenly gave way while walking, as it had frequently done the previous two months. X-ray of the knee showed "soft tissue swelling around the knee joint with marked periosteal reaction along the distal 15 cms., of the shaft of the femur proximal to the metaphyseal area and some irregularity of the bone at the anterior portion of the metaphyseal area." These findings were consistent with periostitis secondary to trauma or infection or both.

Oral terramycin was started November 11, and on November 12 a long leg cast was applied to immobilize the left knee. There was no improvement in the next three weeks. The cast was removed November 24, and she was admitted to the wards November 29.

Examination at admission to the ward showed a normal 12-year-old, white female with moderate fusiform swelling of the left knee, questionable slight patellar ballotment and a small, slightly tender, firm mass over the knee anteromedially. There was moderate pain on flexion and extension of the knee. No lymphadenopathy was found.

Her father had been treated for pulmonary tuberculosis and had had surgery three years previously but no other T.B. exposure was elicited. She had had a poor appetite for one month and a five-pound weight loss.

Histoplasmin and P.P.D. skin tests were negative. C.B.C. and urine analysis were within normal limits. Acid phosphatase was 3.8 and alkaline phosphatase, 2.4.

The chest x-ray was normal and x-rays of the knee now (Figure 1) were characteristic of osteogenic sarcoma with considerable progression as compared to the examination of November 9, 1959. (See next page.)

Open biopsy of a tumor mass arising from the medial greater condyle of the femur was done under general anesthesia December 3, 1959. Pathological report was osteogenic sarcoma.

A tumor dose of 8000 roentgens cobalt therapy was given to the left lower femur December 9 to 18. X-rays December 18 showed

*From the Department of Surgery, University of Louisville School of Medicine, Louisville, Kentucky.



Figure 1

further progression of the tumor of the distal femur and a normal chest x-ray. On December 21 the left lower extremity was removed by classical left hip disarticulation.

She had an uneventful postoperative course and was discharged January 1, 1960 with the amputation stump well healed. Pathological report on the surgical specimen was "osteogenic sarcoma of the distal femur with local vein invasion." Ten normal inguinal lymph nodes were found in the specimen.

She was followed in the orthopedic clinics and continued an uneventful postoperative course. A left hip prosthesis was fitted April 14, 1960. Chest x-rays January 25, May 2, June 3 and July 11 were reported normal, but chest x-ray August 11 (Figure 2) showed a 1.2 x 1 cm. density in the right lower lung field which was also present but much smaller in the previous film of July 11.

She was readmitted August 15, 1960, asymptomatic, in excellent general physical state and well adapted to her prosthesis. Routine laboratory work was within normal limits. A complete x-ray bone survey was normal.

Exploration of the right lung August 20 (eight months following her amputation) revealed two separate nodules, 1 cm. and 0.5 cm. in diameter, in the lateral basilar segment of the lower lobe. A wedge resection of the lateral basilar segment encompassing these nodules was done.

Each of the nodules was found to be metastatic osteogenic sarcoma on tissue examination.

Her postoperative course was uneventful, but, because of the multiple lesions, she was given a total of 16 mgms. of nitrogen mustard intravenously August 31 and September 1. She was discharged September 2 to the clinics.

Follow-up chest x-ray September 12 demonstrated a 0.5 cm. rounded density in the left lower lobe suggestive of metastatic tumor. Conservative therapy was chosen as it was felt hopeless spread had probably occurred. However, she continued to do well clinically, and x-ray of October 17 (Figure 3) showed no additional lung lesions. It was therefore elected to explore the left lung.

She was readmitted October 21 asymptomatic and normal physically except for the left thigh disarticulation and operative scars. Routine laboratory work was within normal limits.

Left thoracotomy October 24 (10 months following her amputation) revealed three sep-

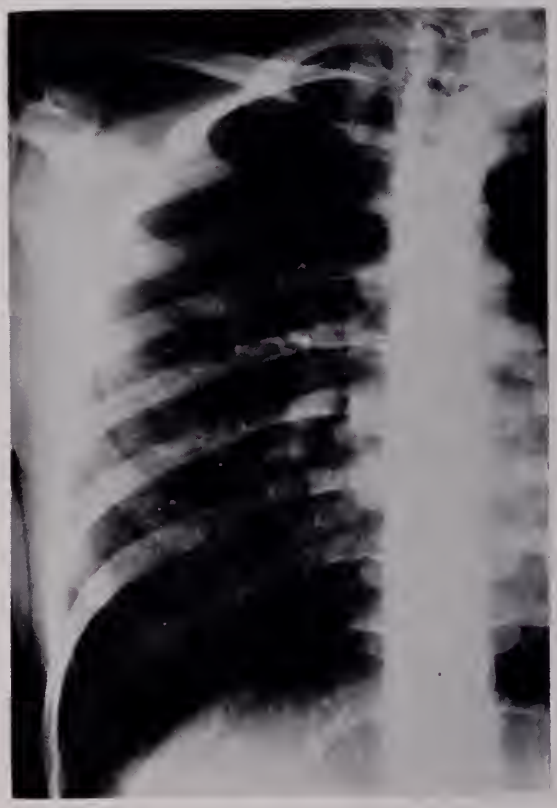
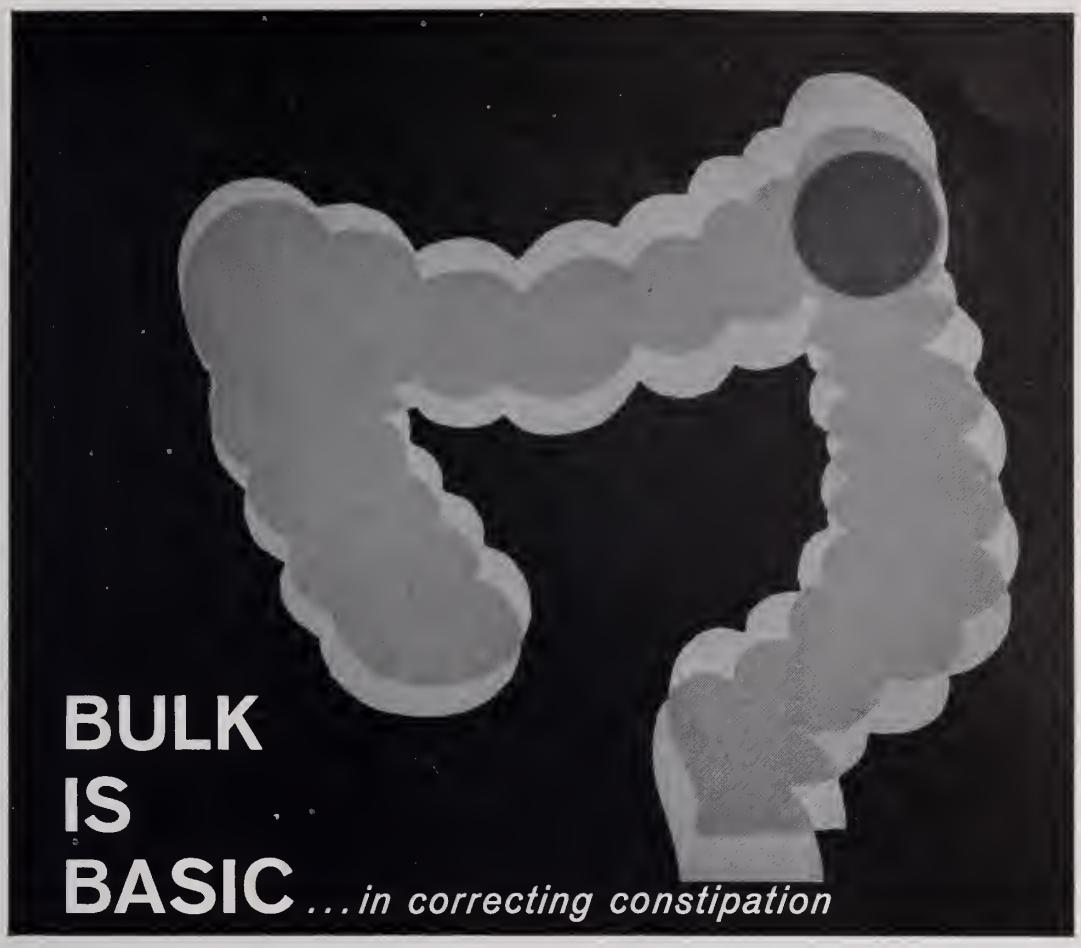


Figure 2



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Research in the Service of Medicine

arate nodules in the superior and lateral basilar segments of the lower lobe, 0.6 mm, 0.2 mm and 0.8 mm in diameter. The remainder of the lung was normal, and no other tumor was demonstrated in the left chest. Two wedges of the lower lobe encompassing the nodules were excised without difficulty.

Her postoperative course was uneventful. Pathological study of the excised nodules revealed metastatic osteogenic sarcoma. She was discharged October 29.

Follow-up chest film of November 2, showed a 1 cm. rounded nodule behind the heart which was suggestive of metastatic tumor but possibly due to postoperative tissue reaction. Definite enlargement to 2 cm. of this density was demonstrated on chest film of January 16, 1961.

She was readmitted January 19 for evaluation. It was elected to manage her as probable hopeless tumor and she was given 18 mgms. of nitrogen mustard intravenously over a four-day period without any difficulty. She was discharged January 27 in excellent general condition and asymptomatic.

Follow-up in the clinics with repeated chest x-rays February 13, March 6 and March 17 showed no change in the left lower lobe nodule nor appearance of any additional nodules.



Figure 3



Figure 4

Chest x-ray of May 8 (Figure 4) showed a marked increase in the size of this nodule although she remained asymptomatic. After considerable discussion it was decided to again surgically excise the visible tumor.

She was readmitted May 15, asymptomatic and in excellent physical condition. On May 17 exploration of the left chest (17 months following hip amputation) revealed a 5 cm. rounded tumor mass arising from the periphery of the medial basilar segment of the lower lobe. This was removed by wedge resection through normal lung tissue proximal to the tumor. Pathological study of the mass showed metastatic osteogenic sarcoma. Her postoperative course was uneventful and she was discharged May 28, 1961.

Regular follow-up examinations following discharge with chest x-rays June 20, August 21, September 22, October 23, November 23, all in 1961; January 3 and March 12, 1962, showed no evidence of recurrence of the tumor or other metastatic lesions. She developed normally and remained asymptomatic. Chest x-ray May 16 revealed an ill defined 2 cm. mass, 3 cms. lateral to the mid-right heart border not seen on the previous films. She was readmitted May 24, 1962 (29 months following her ampu-

tation) for evaluation of this lesion and consideration of further surgery to maintain control of her sarcoma.

Case reports such as that of Barney & Churchill in 1938[1] of a 23-year survival with no recurrence of tumor following removal of a metastatic renal cell carcinoma of the lung have provided strong impetus for further study of the possible cure of metastatic tumors of the lung. Schell[2] in 1961 collected 219 single metastatic lesions of the lung and found that 41% had primary tumors of the colon, kidney or breast and 6% osteogenic sarcomas.

In 1961, Wilkins et al[3] reviewed 75 resections of metastatic pulmonary tumors in 67 patients over a 28-year period in the Massachusetts General Hospital. There was no operative mortality and 26% of the 67 patients survived 5 or more years. They also collected 355 resections of authenticated metastatic tumors from the lung from the available literature. Only about one-half of these had complete five-year follow-ups reported. The operative mortality for this group was 5.6% and the 5-year cumulative survival 37%, an unrealistically favorable figure due to the large number of patients with inconclusive follow-up information or early reporting. It was believed, however, that the figures did tend to confirm the authors' findings and conclusions in their own series.

Wilkins results are concurred in by Streider[4] who reported a 25% five-year survival in 29 patients who had 31 resections for metastatic tumors of the lung and Jensik[5] who reported a 22.2% five-year survival in 45 patients who had resections for similar tumors.

Conclusions that may be drawn from these and many other similar reports are:

(1) Removal of pulmonary metastases in patients whose primary malignancy is controlled results in a 25% five-year survival. This survival rate is identical to that of excisions for primary bronchiogenic carcinoma.

(2) Best results follow excision of pulmonary metastases whose primary lesions are in the colon, uterus or kidney and osteosarcoma. Occasional long time survivals follow removal of pulmonary metastases from practically all primary sites and cell types. Metastatic melanomas do poorly.

(3) Involvement of lymph nodes in the specimen of the primary resection, positive lymph nodes secondary to pulmonary metastases, multiple pulmonary metastases and pulmonary metastases requiring pneumonectomy for control are factors pointing to a poor prognosis.

(4) The more prolonged the period between the control of primary tumor and the appearance of the pulmonary metastases the more favorable the prognosis.

(5) Single or even multiple pulmonary metastases are not necessarily prima facie evidence of widespread extrapulmonary dissemination of a tumor.

(6) Statistically a patient with one cancer is more apt to develop a second primary tumor. A pulmonary mass demonstrated radiographically after successful removal of a primary tumor elsewhere may well be a second primary tumor which can be surgically cured, rather than a metastatic spread of the first primary tumor.

Summary

A case of a 12-year-old, white female who has had six proven metastatic nodules of osteogenic sarcoma excised from both lungs by three thoracotomies over a 17-month period following disarticulation for osteogenic sarcoma of the distal femur is presented. There has been no evidence of spread of the sarcoma beyond the lungs. Twelve months following the last thoracotomy chest x-ray showed another solitary pulmonary nodule for which she is being evaluated for her fourth thoracotomy with excision of probable metastatic lung tumor.

Representative articles from the literature in reference to the surgical excision of metastatic tumors from the lungs are reviewed and the conclusions that can be drawn from the literature presented.

The excision of pulmonary metastases is safe and should be strongly advised when the proper criteria exist. At present no other form of therapy offers a reasonable hope for survival.

(Addendum: A 2 cm. nodule of metastatic osteogenic sarcoma was removed by wedge incision of a portion of the superior segment of the lower lobe of the right lung May 29, 1962. She was discharged June 9. Chest x-ray June 27 showed no additional pulmonary lesions.)

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EDITORIALS



An Appreciation

THREE years' close association with the Board of Trustees and House of Delegates of the State Association has stimulated in me a very real appreciation for the great number of men who conduct the affairs of this Society. The work of the trustees is continuous. There is preparation for, attendance upon and implementation of the decisions of at least six meetings during the year. Sitting through a day-long meeting of the Board of Trustees is a tedious, but an inspiring, experience. It is indeed heartening that these men cheerfully devote so much time and effort to the very ordinary business activities of our Association.

It is, of course, an honor to be elected by one's county society as a delegate to the state convention. This, however, involves a considerable amount of work and attention to detail if the duties and obligations of an official delegate are properly discharged. One is greatly encouraged to observe the interest, the punctuality and the endurance of these delegates during the two grinding and tedious sessions. Patience, tolerance for another's viewpoint, courtesy and goodwill are the characteristics most generally manifested by these men.

During the three years in my capacity as Speaker of the House of Delegates, I had not one single man decline to serve on a committee to which he was appointed without giving a very good, sufficient and understandable reason for his inability to serve. Such cooperation fills one with confidence and optimism toward his fellow men.

Perhaps the most exacting and thankless task in the whole conduct of the Association's business is the work done by the Reference Committees. Here particularly I wish to express my very deep gratitude to the large number of delegates who, during the past three years, have served willingly and effectively in this capacity. They receive little public recognition for their service. Their only satisfaction is better acquaintance with the social, economic and professional facets of the Medical Profession, and the satisfaction of an assignment well discharged.

Many very gracious expressions have been passed to me concerning the conduct of the House of Delegates business. It has not always been possible to explain that whatever efficiency and facility has been achieved was due in the greatest part to the meticulous care and preparation for these meetings which Mr. Joe Sanford and his staff have always exercised. Their work before, during and after a state convention is grueling and exhausting. I believe that he, more than any other individual, is due credit for our progress as an Association during the past 12 years — and we have made most commendable advancement during that time.

To have served the Kentucky State Medical Association as its speaker for a period of three years is an honor which I shall long cherish and an experience which I shall not easily forget. It has been most pleasant and stimulating. It has led to a very deep appreciation for my fellow physicians and their devotion to the cause which we all attempt to serve.

Sam A. Overstreet, M.D.

Vote! To Keep Medicine Free

WHAT obligations do we, as physicians, have in relation to good government and the democratic process? Are we to sit aside as a profession and say we shouldn't express opinions because by so doing we would be mixing medicine with politics? The answer is an emphatic "No!"

We, as physicians, are citizens of this state and nation just like anyone else. We owe to our patients understanding, comfort and high standards of medical care. But we also owe to our patients and all other citizens sound and considered judgment pertaining to local, state and national governmental processes.

To anyone who says doctors should not be interested in politics, we say, "We cannot stay out of politics without being a victim of it!"

During the past several months (and years for that matter) many of us in Kentucky, and indeed throughout the nation, have made a concentrated effort to reveal to our fellow citizens the vast pitfalls and ruinous effects of socialized medicine, even when given in small doses such as the King-Anderson Bill.

We have journeyed far and wide to gain the ear of our Senators and Congressmen in efforts to have such legislation defeated in the U. S. Congress; legislation which we sincerely feel would be detrimental to our nation as a whole.

But has it occurred to all of us that there are areas closer to home than Washington where we may work effectively for better government? These areas are precincts where we live day by day.

We have all heard the comment, "Why should I vote? My one vote couldn't possibly matter." But do you know that if Nixon had received one-half vote more per precinct that he would be President today? And that if Clements had received one and one-half votes more per precinct that he would be one of our Senators today? Regardless of who your political favorite may be, you would have to agree that one vote, your vote, is extremely important.

We frankly believe that there is not a doctor in Kentucky who could not cause a minimum of 50 people to vote who would not have voted otherwise. If all doctors in Kentucky worked to this end, this would be 140,000 votes.

On November 6, only about four weeks away, those of us in Kentucky will elect a Senator who will serve six years. The time has arrived for all physicians to acquaint themselves with the issues and the candidates. The time has arrived for organizational work at the precinct level—your precinct.

When you have made your decision, you owe it to the candidate of your choice to vote, and we believe that we as physicians should not only vote but should actively support the candidate of our choice.

We frequently hear the comment, "What could I do that would actually help besides vote?" We could place bumper stickers on our cars; we could wear our candidate's button during office hours, hospital rounds and everywhere else.

When a patient is sick and goes to his physician for treatment he doesn't want to discuss politics. But who would object to his physician's merely wearing a button on his lapel or shirt? We believe no one. If the patient brings the subject up as a result of the button this is evidence that he wants to discuss the candidates and we feel that it is our duty to do so. There is no reason why we, as individuals, should not make our political convictions known to the general public, whether it be by personal conversation or newspaper ad.

Come November 6, it is our American duty to vote and to see that our families, personnel and friends vote. If we are called on to work at the polls as challengers, checkers or in other capacities to see that fairness and honesty prevail at the polls, this we should do. A few illegal votes could mean the difference in winning or losing.

If we don't do this, and all other sound-minded, levelheaded Americans take the same apathetic attitude toward politics and government, we are headed for socialism for your children and my children just as sure as the sun comes up tomorrow.

Fred C. Rainey, M.D.

Diabetes Detection

THERE are approximately 3,000,000 diabetics in the United States of whom 1,400,000 are unaware that they have the condition, according to new figures recently released by the committee on statistics of the American Diabetes Association. Perhaps as many as 125,000 more are potential diabetics.

Because diabetes is primarily a disease of older people its statistical rise is inevitable in a world with an aging population. These facts help to point up the importance of the methods of detection of diabetes in general and of Diabetes Detection Week, November 11 to November 17 in particular. Every physician in the United States and in Kentucky is urgently requested to participate in this concerted endeavor.

The methods of diabetes detection are: (1) Diagnosis by the family physician; (2) Individual self screening with urine tests, and (3) Large scale mass screening programs.

Diagnosis by the family physician has been and always will remain the mainstay in diabetes detection. All other methods of test screening merely serve to bring possible suspects to the attention of the family physician for more definite diagnosis.

It is the technique of the mass screening program designed to reach as many individuals as possible to which we turn our attention during Diabetes Detection Week and which technique is the subject of the present communication.

Large-scale mass screening programs using blood and/or urine tests have been in use since 1947. A successful screening campaign during Diabetes Week requires no elaborate equipment or public fund raising. Rather it depends for its effectiveness on organizational effort volunteered by the physicians of a community with the cooperation of other professional and lay groups.

The campaign has as its aims: (1) To screen as many persons as possible in the community for diabetes and get those whose tests prove positive to go to their physicians. (2) To make sure that all physicians receiving positive reports follow them up with blood sugar determinations and other tests necessary to establish whether or not diabetes is present. (3) To make the community "diabetes conscious"—aware of the need for both detection and control.

Sponsorship and direction are the responsibility of the committee on diabetes of the county medical societies and local diabetes associations where one has been established. Methods of testing which may be used include one of the various urine tests for the presence of glucose or reducing substances, a blood sugar determination or the "Clinitron," a machine which tests for blood sugar in amounts above a preset level. Any individual having a positive test by one of these methods is then referred to his family physician for further diagnostic tests. It should be emphasized that a positive result by any of these methods is not diagnostic, but urgently requires further diagnostic study.

Diabetes mellitus can be defined as an abnormal metabolic state induced by deficient insulin activity. At the present time the most sensitive clinical index of the existence of this state is afforded by the glucose loading tests. Recent developments supporting the concept of genetic determinants in the development of diabetes indicate that the basic abnormality in diabetes is present from conception.

In many cases this abnormality precedes by many years the clinical evidence of deficient insulin activity. During these "prediabetic" years generalized angiopathy and fetal complications of pregnancy characterizing the diabetic syndrome may appear. Future researchers working in the field of earlier diabetes detection and ultimate prevention of diabetes may detect abnormalities other than those related to carbohydrate metabolism which could detect the "diabetic trait" before insulin deficiency occurs. It is logical to assume that the largest numbers of individuals carrying such genetically determined metabolic derangements will be found among families of diabetics and diabetic suspects. This wide new horizon of future research activity will have an important impact on all fields of medicine.

The challenge to detect as many people as possible who may become diabetes suspects or kin of diabetes suspects is even greater in the year 1962.

Robert S. Tillett, M.D.

(Ed. Note: See News Story on page 977.)

NEW **SPECIAL COUGH FORMULA** *for Children*

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SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 cc.) contains:

Codeine phosphate	5.0 mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5 mg.
Chlorpheniramine maleate	0.75 mg.
Potassium iodide	75.0 mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

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ORGANIZATION SECTION

Blue Cross-Blue Shield Offer Plan For Senior Citizens in October

The new Blue Cross-Blue Shield Senior Citizens plan will be offered to Kentuckians 65 years of age and older during October only, according to an announcement by the Blue Cross Hospital Plan and the Kentucky Physicians Mutual.

The announcement pointed out that more than 80,000 people in Kentucky over age 65 are already members of Blue Cross-Blue Shield.

The plans have broad provisions for hospital protection and surgical-medical bills with allowance for nursing homes, doctors' visits, diagnostic services and visiting nurse services. There will be a six-month waiting period for protection for pre-existing conditions.

The Kentucky program is a part of the national effort to provide coverage for senior citizens sponsored by the American Medical Association, the American Hospital Association, the National Association of Blue Shield Plans and the Blue Cross Association. It is offered in Kentucky with the cooperation of the Kentucky State Medical Association.

The current issue of the Blue Shield "Newsletter" has additional information regarding this voluntary health care program.

(Ed. Note: Additional information on the Senior Citizens program of Blue Cross-Blue Shield is presented on The Insurance Page in this issue. See page 934.)

Kentucky Chest Physicians Elect

At the September 18 dinner meeting of the Kentucky Chapter of the American College of Chest Physicians at the Brown Hotel, Louisville, Daniel E. Mahaffey, M.D., Louisville, was elected president. Other officers elected: Lloyd D. Mayer, M.D., Lexington, vice president, and John B. Floyd, Jr., M.D., Lexington, secretary-treasurer.

Information Center Opens

A new organization, sponsored by the United States Public Health Service, the State Health Department and the Health and Welfare Council of Louisville and Jefferson County, has been organized to provide information to people with chronic health problems. The Information Center for the Chronically Ill is headed by Miss Ruth Dalton, trained social worker.

J. Duffy Hancock, M.D., Louisville, heads a 12-man executive committee representing various professional fields and health institutions to work with the agency, which is also assisted by a 56-man Citizens Committee.

All KSMA Members Urged to Push Diabetes Detection Drive

All members of the Kentucky State Medical Association are urged to participate in the annual 1962 Diabetes Detection and Education Drive by Robert S. Tillett, M.D., Louisville, chairman of the KSMA Diabetes Committee.

The Drive is being sponsored again this year by the KSMA in cooperation with the American Diabetes Assocation. It will be held the week of November 11-17. (See Editorial on page 974.)

Of the counties that have indicated that they will participate, approximately 35 still have not sent in orders for free Clinistix, according to Doctor Tillett. Chairmen of the county diabetes committees should order the Clinistix through the Kentucky State Medical Association, 3532 Janet Avenue, Louisville 5, Ky.

All Kentucky physicians are asked to take part in the program and check urine samples free for the week of the drive.

In 1961 approximately 54,250 free tests were made and 240 proved cases were reported.

Approximately 1,850 previously unknown diabetics have been found since the first drive was held in 1951.

Other members of the KSMA Diabetes Committee are: Esten S. Kimbel, M.D., Frankfort; Lewis Dickinson, M.D., Glasgow; Frank H. Moore, M.D., Bowling Green, and Cordell H. Williams, M.D., Hazard.

November Journal To Carry Full KSMA Annual Meeting Story

Full coverage of the 1962 Annual Meeting of the Kentucky State Medical Association at Louisville, September 18-20, will be carried in the November issue of The KSMA Journal. A resume of the business sessions, highlights of the scientific presentations and picture coverage of some of the outstanding features of the Annual Meeting will be presented. Be sure to read your November KSMA Journal thoroughly.

Doctor Thompson Promoted

Edward M. Thompson, M.D., has been named acting director of local health in the Kentucky State Department of Health, Frankfort, succeeding Edwin H. West, M.D., who resigned to enter private practice in Carter County.

Russell E. Teague, M.D., commissioner of health, who made the announcement, said Doctor Thompson, who has been assistant director since 1959, is "one of the best public health physicians in the State." Doctor West joined the Department in 1958 and was director of local health for four years.

KSMA Presents Certificates for 100% Seat Belt Installation

The Board of Trustees of the Kentucky State Medical Association on request of the KSMA Highway Safety Committee, headed by Arthur H. Keeney, M.D., chairman, established this summer an official recognition and award plaque for organizations securing 100% seat belt installation in all passenger vehicles operated by its membership.

Certificate No. 1 was formally presented to the Highland Lions Club of Louisville at their monthly dinner September 6, according to Doctor Keeney. Jim Wiseman, club president; Edward Reynolds, safety chairman, and Gilbert Morris, project director, were commended in the words of the citation, "not only for active concern over the survival of its own members and their families, but for leadership and example set to all people."

Through its seat belt drive, the club has not only protected its members, their families and friends, but has earned $3,000 to finance other community projects, Doctor Keeney pointed out. The Highland Lions Club has received stimulation and technical assistance from Charles Solley of the Louisville Automobile Club. They are now expanding their efforts to make all Lions clubs in the city "100%'ers."

Certificate to Sears, Roebuck

Certificate No. 2 was presented in the office of Cyril J. Deutsch, September 13, to Milan Booth and the service station staff of Sears, Roebuck & Co., Louisville. As manager of auto equipment lines, Mr. Booth has sold safety and promoted seat belts until every aide, mechanic and attendant on his staff installed them in all their cars.

With the development of such understanding conviction in every service station employee, Mr. Booth and the service station manager, Marvin Bryant, then began a five-months' sales campaign using a wrecked car and partially ejected dummy on an elevated block immediately next to their shops. Nearly 3,000 seat belts were sold and installed during this time.

"The KSMA Highway Safety Committee," said Doctor Keeney, "is anxious to learn of other organizations, service clubs, PTA groups, fraternal orders or commercial groups who have adopted 100% belt installation."

Belts are strongly urged for *each* passenger seat in every vehicle. Statistically, greatest danger is, of course, associated with the right front or suicide seat, but many well documented deaths, such as those of General George Patton and Jefferson County Judge George Wetherby, have struck rear seat passengers, even when the drivers have escaped, he said.

Postcard re-survey of 500 KSMA members in July 1962, he added, indicates that belt usage by physicians is now up to 67%, as compared to 34% when the KSMA Highway Safety Committee was created 18 months ago.

Vester A. Jackson, M.D., has resumed the practice of medicine at Clinton, Ky., after spending the summer at Lexington.

Health-O-Drama Is Featured at 1962 Kentucky State Fair

The first Health-O-Drama in Kentucky State Fair history was officially opened by Governor Bert Combs, September 7. Gaithel L. Simpson, M.D., Greenville, 1961-62 president of the Kentucky State Medical Association, was among those in attendance for the ceremony.

Telling the story of Kentucky's vital health services, Health-O-Drama is a combined and cooperative effort of interested groups to demonstrate to the people of Kentucky some of the measures being taken to protect their health and to educate the people to become more health-minded.

Organized and promoted by the Council on Allied Services, Health-O-Drama became a "health fair" within the State Fair. Some 14 organizations that participated in this year's project expect Health-O-Drama to steadily grow each year and to offer even more services to the Fair patrons.

Free tests and medical services were included in this year's exhibits. The "Transparent Twins" and a 16-foot exhibit on the "Eye" comprised the booth presented by the Kentucky State Medical Association.

Southern Medical Association To Meet November 12-15

The Southern Medical Association will hold its 56th annual meeting November 12-15 at Miami Beach, Florida. A. Clayton McCarty, M.D., Louisville, is president of the Association.

Edward R. Annis, Miami, president-elect of the American Medical Association, will be the featured speaker at the President's Luncheon November 13.

General sessions will include symposia on endocrinology, office problems, astromedicine; and scientific color television programs on many phases of medical practice.

In addition to the meeting of the SMA, other medical groups holding sessions during the period will be: Southern Chapter, American College of Chest Physicians; College of American Pathologists, Gulf and Southeast Regions; Radiological Society of North America; Southern Gynecological and Obstetrical Society.

Thomas H. Baker, M.D., has begun the practice of obstetrics and gynecology at Frankfort, Ky. Doctor Baker was graduated from Vanderbilt University Medical School in 1956. He interned at Duke University Hospital and served his residency at Vanderbilt University Hospital. He served two years in the U. S. Air Force with the rank of captain and was a cancer trainee at the National Cancer Institute of the Department of Health, Education and Welfare.

Billie Jo Caudill, M.D., has started general practice at Morehead, Ky., in association with **C. Louise Caudill, M.D.** Doctor Caudill received his M.D. degree in 1961 from the University of Louisville and interned at St. Joseph Hospital, Lexington.

U. of L. Medical School Receives Endowment from Doctor Rice

Dennis B. Rice, M.D., Rock Island, Tenn., recently established a $250,000 endowment fund to the University of Louisville School of Medicine. The endowment represents the largest gift ever made to the University by any living alumnus.

Doctor Rice was graduated from the Medical School in 1909. He practiced medicine in Wisconsin and later operated a hospital in South Dakota. He is now retired from medical practice.

A native of Paintsville, Ky., Doctor Rice said in announcing the endowment, "I hope this gift will be helpful to the young men and women who are now planning to enter the medical profession." He pointed out, "My education at the Medical School made it possible for me to serve a great many people as well as to provide security for myself and my family."

Mrs. Rice will receive an annual income from the University during her lifetime. The money will come from returns on investments purchased by the fund.

Dr. Philip Davidson, president of the University, said, "This gift is very important to us here at the University. Not only is it a very substantial sum which will help strengthen our medical program, but it is a fine example of the loyalty of an alumnus to his school." He added, "This kind of life-income agreement is a relatively new means of providing financial support both for us and other universities and colleges. We think this is an important new pattern for support from individuals."

Doctor Wilson on Space Study Team

Michael F. Wilson, M.D., with the University of Kentucky Medical Center, Lexington, will assist in a U. of K. study over the next three years investigating man's physiology in space flight. A grant of $215,000 has been made by the U. S. Air Force to finance the study. Others working on the project are Loren Carlson, Ph.D., chairman of the U. of K. Department of Physiology, and Dr. Fred W. Zechman, assistant professor of physiology.

Doctor Wilson will study the reaction of the heart and circulatory system during changes in environmental temperature.

James F. Williamson, M.D., has started the practice of obstetrics and gynecology at Ashland, Ky., in association with **John H. Neyer, M.D.** Doctor Williamson was graduated from the University of Louisville School of Medicine in 1957 and interned at St. Elizabeth Hospital, Covington. He took residency training at Louisville General Hospital.

Charles R. Perry, M.D., has opened an office for the practice of internal medicine and cardiology at Covington, Ky. Doctor Perry was graduated from the Medical School of the University of Cincinnati in 1954. He interned at St. Elizabeth Hospital, Covington, and took residency training at Louisville General Hospital. He spent two years in the U. S. Army as a captain.

Fleming Co. Hospital Opens

Fleming County Hospital at Flemingsburg Ky., was dedicated at a special open house and ceremony August 12. The program included addresses by Paul Hackney, director of the Division of Hospitals and Medical Facilities of the Kentucky State Department of Health, and Hasty Riddle, executive director of the Kentucky Hospital Association. Benjamin F. Allen, M.D., president of the Fleming County Medical Association, is chief of staff.

Physicians Support Nurse Fund

The Warren County Medical Society has presented a check for $500 to the nurses' scholarship fund sponsored by the Bowling Green Business and Professional Women's Club. This is the 10th year the Society and the Club have cooperated in sponsoring the project which is used to pay tuition for Warren County girls who wish to enter nursing. The fund pays most of the tuition of these students at schools in Louisville and Nashville.

KSMA Lists New Members

The following new members—all of Glasgow, Ky.—have joined the Kentucky State Medical Association: Donald Aspley, M.D.; Coy E. Ball, M.D., and William J. Oliver, M.D.

John Peter Wyles, M.D., 81, Cynthiana, Ky., a general practitioner in Harrison County for 51 years, has retired from active practice. He was graduated from the Medical Department of the University of Louisville in 1910. **Richard T. McMurtry, M.D.,** has been named Harrison County physician to fill out the unexpired term of Doctor Wyles. The term ends in 1963.

Lafayette G. Owen, M.D., who practiced at Hardinsburg, Ky., during July and August of 1962, will serve for the next two years as a captain in the U. S. Air Force stationed at Wichita Falls, Texas. Doctor Owen was graduated from the School of Medicine at the University of Louisville in 1961 and interned at St. Joseph Infirmary, Louisville.

Edward C. Bowling, Jr., M.D., Lebanon, Ky., has moved to Rochester, Minn., where he is taking residency training at Mayo's.

Elmer A. Gearhart, M.D., has begun the practice of internal medicine at Owensboro, Ky. Doctor Gearhart received his M. D. degree from the University of Tennessee in 1941. He interned at Charleston, W. Va., Hospital and Charleston General Hospital. Doctor Gearhart served in the Air Force for three and one-half years as a captain in the medical corps. He has previously been in general practice and internal medicine.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

U. of K. Offers Chest Diagnosis Postgraduate Course

A postgraduate course in "X-Ray Diagnosis of Chest Diseases" is being offered by the University of Kentucky Medical Center's Department of Radiology on five successive Thursday evenings, beginning October 18.

The sessions will be held at 7:30 p.m. in the Center.

The purpose of the program is to refresh the general practitioner's knowledge of the role of roentgenology in the diagnosis of chest disease. Formal presentations will be an hour each, followed by 30 minutes of questions and answers.

Various forms of visual material such as x-ray films (projected with the Gordon projector), lantern and 35 mm. slides from the departmental slide collection, copies of illustrations in textbooks, etc., will be used.

The course is designed primarily to help the general physician evaluate the reports he receives from the roentgenologists; to help the physician gain more understanding of the problems facing the roentgenologist, and third, to attempt to define a "healthy attitude" on the part of the clinician toward the report he receives from the specialist.

Course in Electrocardiography

A postgraduate course in "Electrocardiography Interpretation" will be offered by the Section on Cardiology, Department of Medicine, University of Louisville School of Medicine Thursday evenings from November 7 through January 16, 1963 at Louisville General Hospital.

Faculty members, all of the U. of L. School of Medicine will be: Herbert L. Clay, M.D., associate professor of medicine and chief of the Section on Cardiology; Ralph M. Denham, M.D., instructor in medicine, and Maurice M. Best, M.D., associate professor of medicine. Registration fee is $35. The course will be limited to 25 practicing physicians. For further information call the Office of Postgraduate Medical Education of the Kentucky State Medical Association, GL 4-6324.

IN KENTUCKY

OCTOBER

10	Lexington Clinic, Lexington, Kentucky.
10, 17, 24, 31	Jefferson County Chapter Academy of General Practice, Fall Seminar, Louisville, Kentucky.
11	"Mammography," J. Gershon-Cohen, M. D., 7:30 p.m., University of Kentucky Medical Center, Lexington, Kentucky.
12	Kentucky Radiological Society, Sheraton Hotel, Louisville, Kentucky.
18	KAGP Seminar, Maysville, Kentucky.
18-25 Nov. 1-8-15	"X-Ray Diagnosis of Chest Diseases," 7:30 p.m. University of Kentucky Medical Center, Lexington, Ky.
25	Kentucky Rural Health Conference, Cumberland Falls, Kentucky.

NOVEMBER

1-8-15	"X-Ray Diagnosis of Chest Diseases," 7:30 p.m., University of Kentucky Medical Center, Lexington, Kentucky.
9	Kentucky Radiological Society, Sheraton Hotel, Louisville, Kentucky.
7-14-21-28	"Electrocardiogram Interpretation," 7 to 9:00 p.m., Thursday evenings, Louisville General Hospital, Louisville, Ky.
8-10	KAGP Interim Meeting, Phoenix Hotel, Lexington, Ky.

Surrounding States

OCTOBER

3-5	"Diseases in the Newborn Infant," University of Tennessee Medical School, Memphis, Tennessee.
8-10	Indiana State Medical Association, French Lick Sheraton Hotel, French Lick, Indiana.
12	Mississippi Valley Thoracic Society with the Mississippi Valley Conference on Tuberculosis, Claypool Hotel, Indianapolis, Indiana.
15-19	American College of Surgeons, Atlantic City, New Jersey.
15-19	11th Annual Conference of the U. S. Civil Defense Council, White Memorial Coliseum, Knoxville, Tennessee.
17-19	"Obstetrics and Gynecology," University of Tennessee Medical School, Memphis, Tennessee.
22-23	American Cancer Society Annual Session, New York, New York.
26-28	American Heart Association Annual Meeting, Cleveland, Ohio.
28-31	American College of Gastroenterology, Morrison Hotel, Chicago, Illinois.

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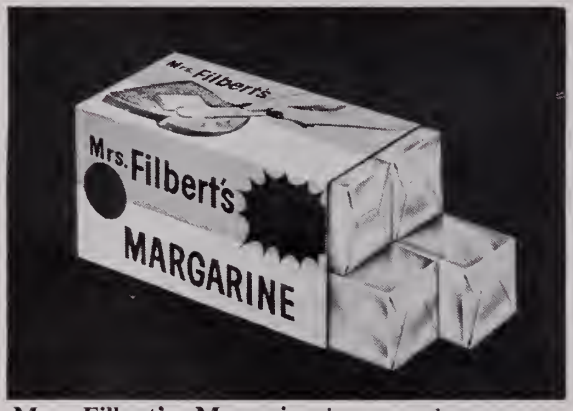
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*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).



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1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



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Side Effects: Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

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Prescribing information adopted Jan. 1961

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In Memoriam

RICHARD MORRIS GOLDSBOROUGH, M.D.
1890 - 1962

Richard Morris Goldsborough, M.D., 72, Louisville, Ky., general practitioner, died September 2 at Kentucky Baptist Hospital, Louisville. He had retired a year ago because of ill health.

Doctor Goldsborough was graduated from the Medical Department of the University of Louisville in 1915, interned at St. Joseph Infirmary and served during World War I as a Medical Corps captain in France. He had practiced in Louisville since 1919.

Doctor Goldsborough was the son of a physician, the late Charles Nelson Goldsborough, M.D., and the father of John N. Goldsborough, M.D., Louisville internist.

CLARENCE DeWEESE, M.D.
1880 - 1962

Clarence DeWeese, M.D., 81, Lexington, Ky., eye, ear, nose and throat specialist, died at St. Joseph Hospital in Lexington, August 13. He had practiced medicine for 55 years prior to his retirement in 1961.

Doctor DeWeese was graduated from the Hospital College of Medicine, Louisville, in 1906 and entered general practice at Horse Branch. Ky. He took eye, ear, nose an throat training at Tulane University in 1910 and 1912. He served in the Medical Corps during World War I, entering as a lieutenant and being discharged as a major.

Doctor DeWeese began his practice at Lexington in 1920.

JOHN CLINTON TUCKER, M.D.
1874 - 1962

John Clinton Tucker, M.D., 88, in general practice at Leitchfield, Ky., for more than 50 years, died September 4 at Methodist Evangelical Hospital, Louisville. Doctor Tucker was graduated from the Kentucky School of Medicine at Louisville in 1904. It was Doctor Tucker who delivered the Lashley quadruplets at the Lashley farm home in 1941. All are still living.

ELMER RICHARD SCHNAKE, M.D.
1899 - 1962

Elmer Richard Schnake, M.D., 63, Newport, Ky., died at Speers Hospital, August 12, after suffering a heart attack at his home. Doctor Schnake was a 1924 graduate of Eclectic Medical College, Cincinnati, and served his internship at Bethesda Hospital in that city. He had served as Newport health officer for the past 22 years. Doctor Schnake was a World War I veteran.

H. B. WINTER, SR., M.D.
1875 - 1962

H. B. Winter, Sr., M.D., 87, Murray, Ky., retired physician, died July 29. Doctor Winter was graduated from the St. Louis College of Physicians and Surgeons in 1905 and interned at Paducah. He retired from active practice in 1948. He was veteran of the Spanish American War.

KSMA Trustee District Meetings
Sixth District

The Sixth Trustee District Medical Society met September 11 at Western Hills Restaurant, Bowling Green, Ky., with 35 members and three guests present.

After a social hour and dinner, a brief discussion was held by several members of the society regarding KEMPAC and the importance of selecting the right candidates in the coming election. Following this, Bobby Grogan, field secretary of the Kentucky State Medical Association, discussed the program for the KSMA Annual Meeting, September 18-20, and John P. Glenn, M.D., sixth district trustee, discussed his recommendations regarding financing of medical care for the aged.

Following the business session a program on hemorrhagic diseases and their treatment was presented by Ellis A. Fuller, M.D., Louisville. The next meeting will be held in Glasgow in November.

Purulent Meningitis

(Continued from Page 952)

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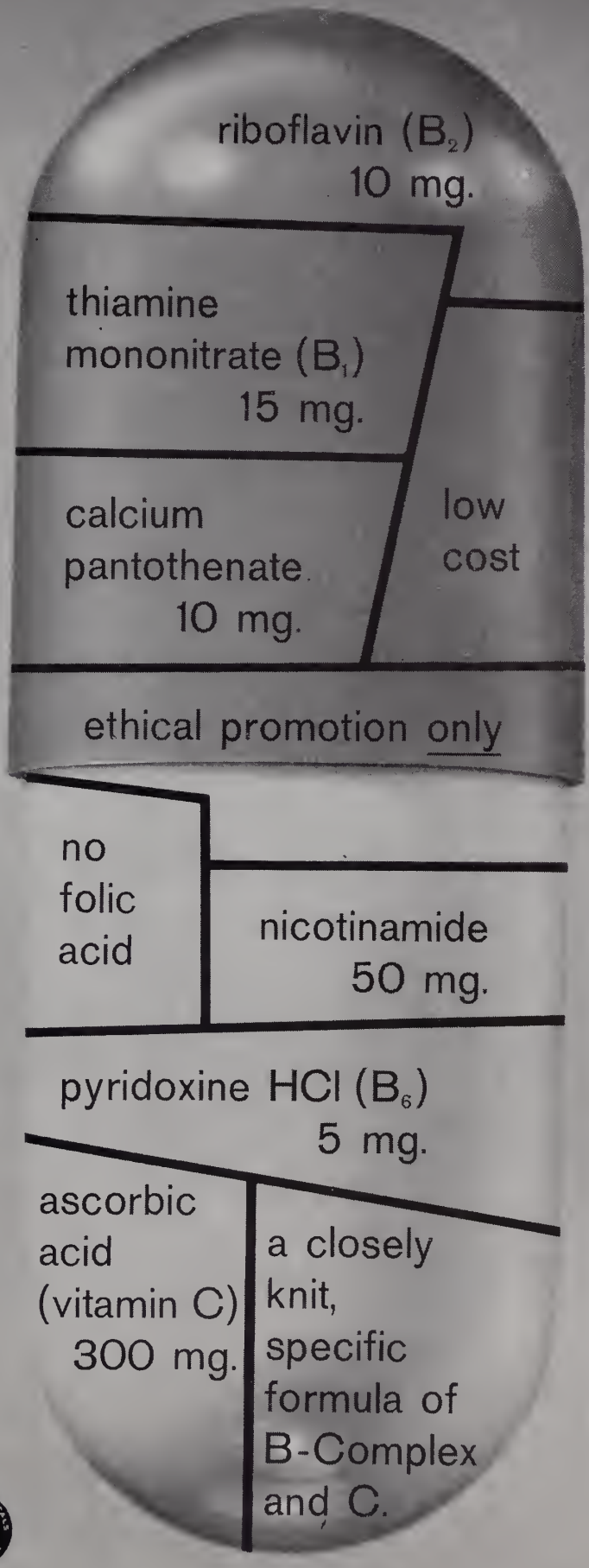
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In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



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Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P. ...	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P. ...	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

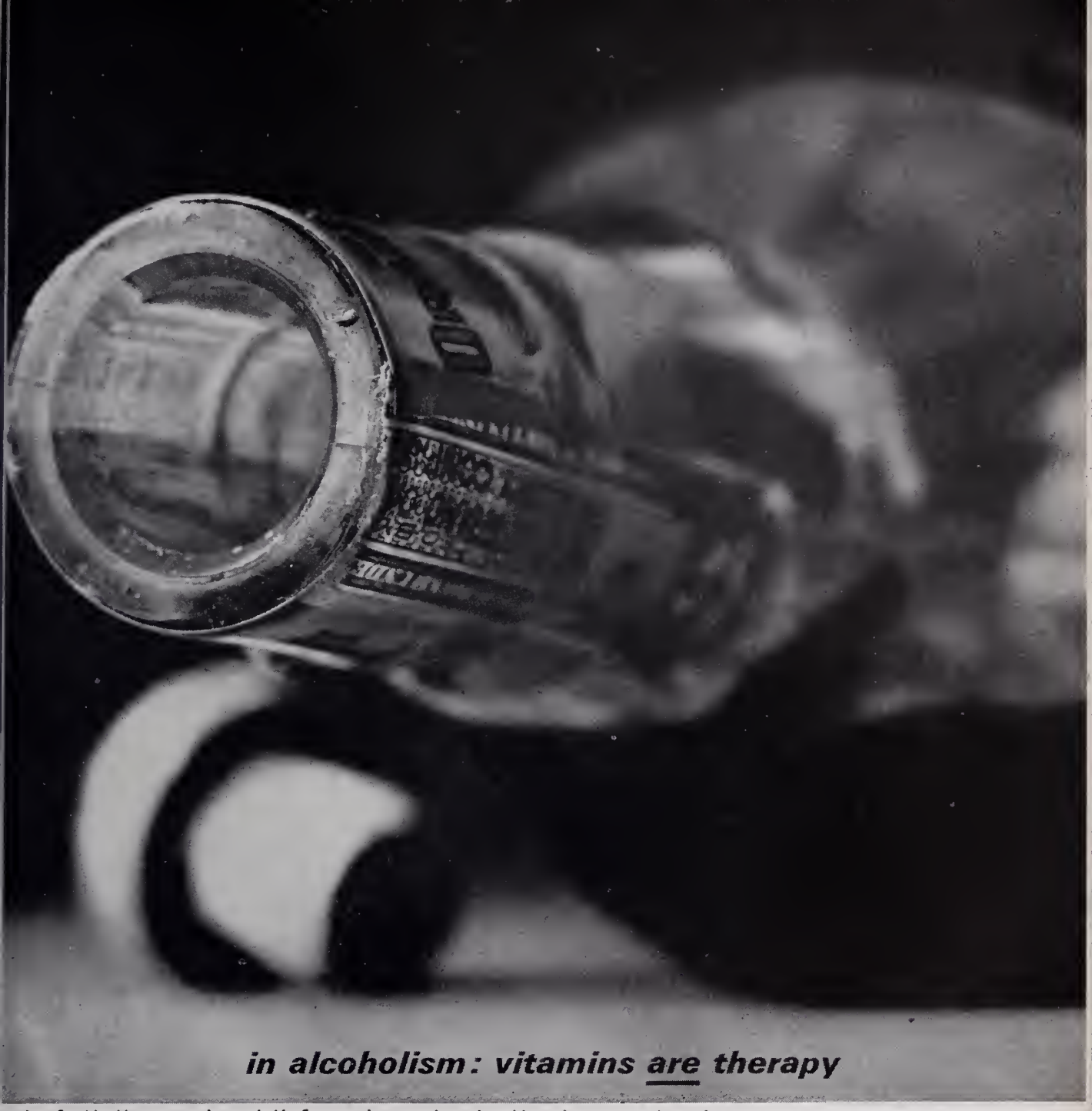
Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.





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Each capsule contains:	
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Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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BENEFICIAL RESULTS were obtained with **SARDO** in the bath in 122 of 135 patients (90%) with dry, itchy skin conditions, in most cases with beneficial effect "after the first bath." Dryness was allayed in all cases, and associated itching "either completely relieved or greatly improved." No irritation or sensitization was observed.

This new study corroborated others[2-4] showing that SARDO helps re-establish the normal physiologic lipid-aqueous skin balance.

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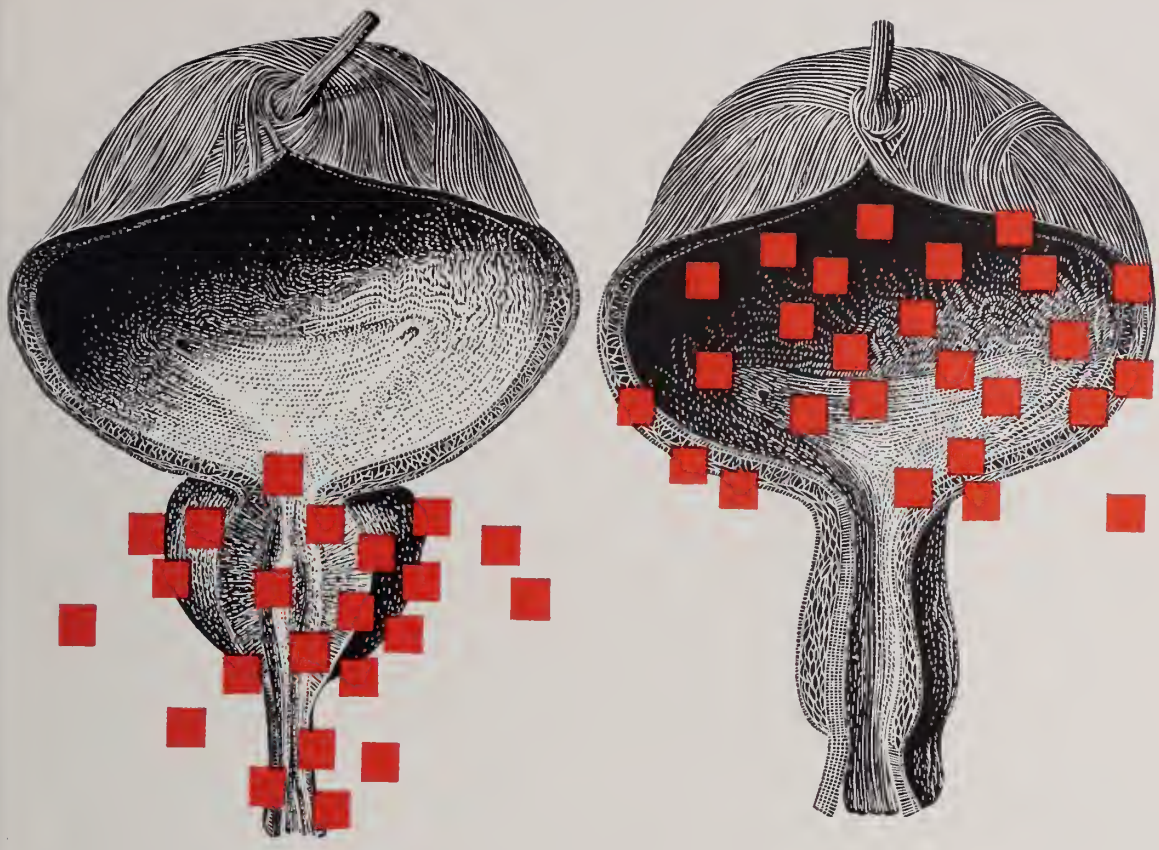
*Patent Pending T.M. © 1962 by Sardeau, Inc.

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1. Borota, A., and Grinell, R.N.: J. Amer. Geriatrics Soc., 10:413, 1962.
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Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

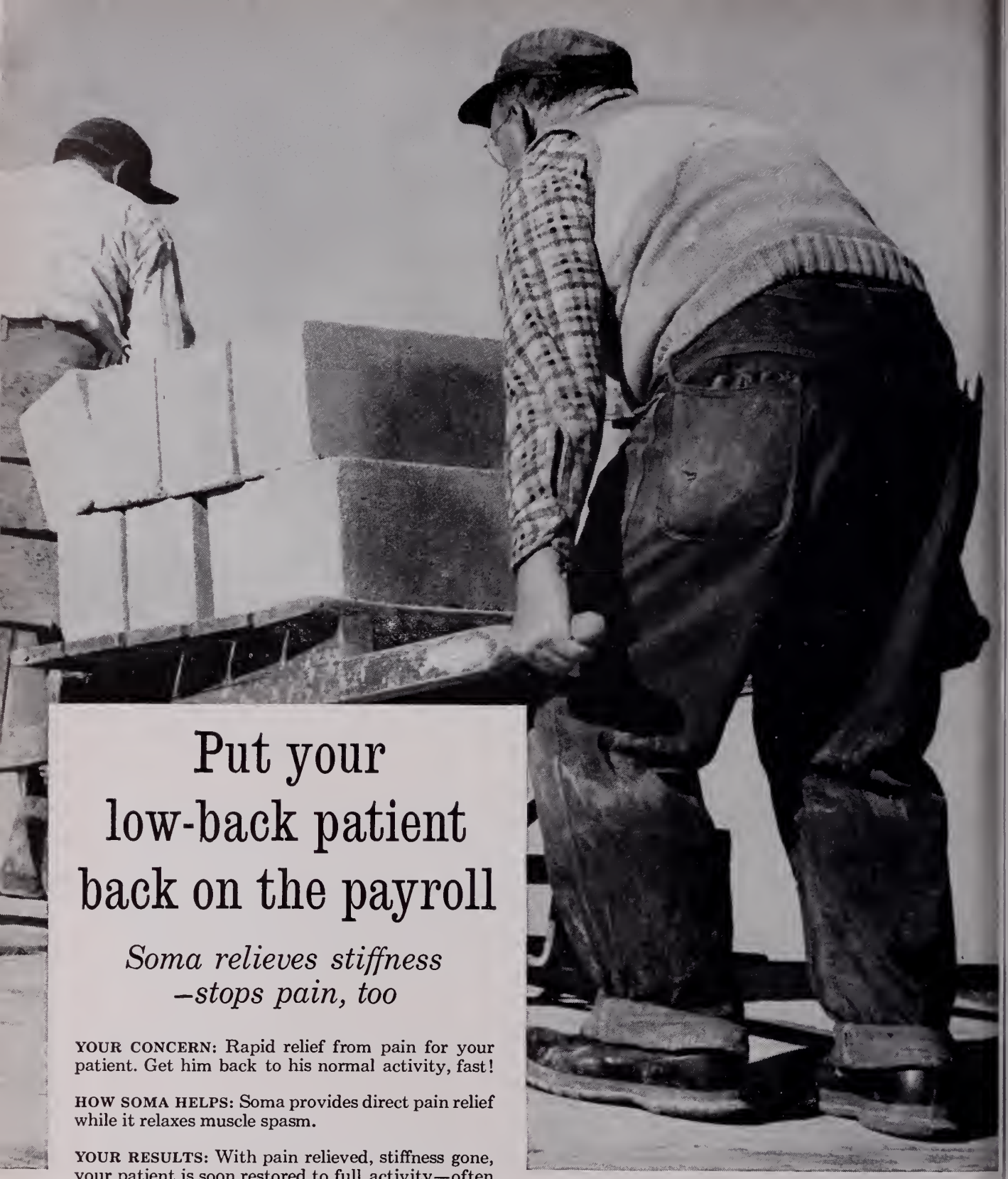
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Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

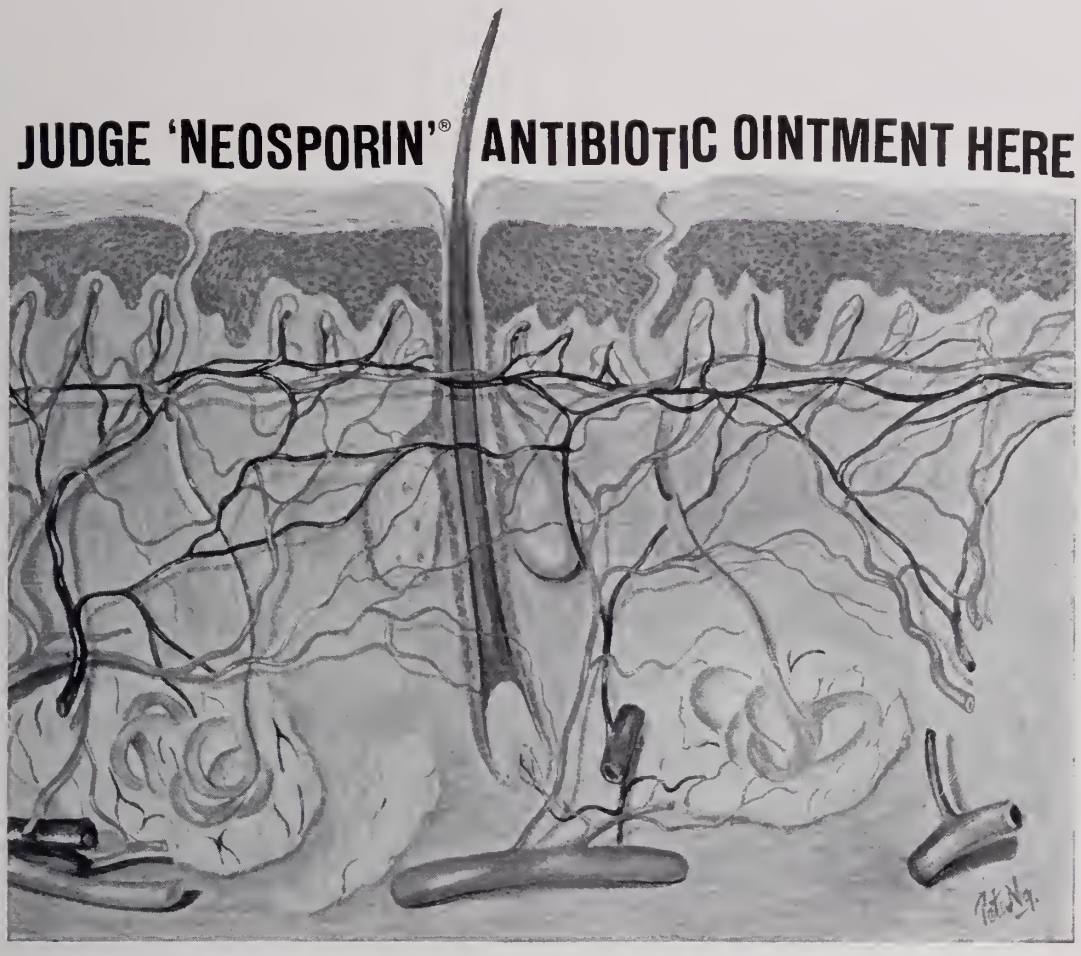
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Results on SKIN are the true test of a topical anti-infection agent. Because no *in vitro* test can duplicate a clinical situation in living skin, clinical use alone proves topical effectiveness. In thousands of cases of bacterial skin infection, consistently good results prove that 'Neosporin' Ointment works where topical efficacy counts—on the patient's skin. Why? The antibiotics diffuse readily from the special petrolatum base since they are insoluble in the petrolatum but readily soluble in tissue fluids.

'Neosporin' Ointment is bland, and rarely sensitizes.

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Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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PUBLIC HEALTH PAGE

A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILDBIRTH PAIN; by C. Lee Buxton, M.D.; published by W. B. Saunders Co., Philadelphia; 116 Pages; price $4.75.

This survey reports the author's impressions of different techniques of mental and physical training for relief of pain in childbirth as observed in over 30 clinics in the United States and Europe.

The nature of the pain and "suffering" is discussed. This gives a background for a study of the psychophysical approach to ameliorate and prevent this pain and "suffering" without the use of pharmacological aids.

Among the methods surveyed are the natural childbirth of Grantly Dick Read, autogene training, hypnosis and psychoprophylaxis. The principles and results of these methodologies are presented and evaluated as to their advantages, disadvantages and practicality in the practice of obstetrics.

The book is timely in that there is considerable interest in these methods. It is tedious to read, possibly because many direct quotations from various authors are used. Unless one is familiar with the various methods there is not enough specific information concerning technique to enable one to evaluate the procedures for himself or to employ the method without further reading.

W. P. Eubank, M.D.

RESPIRATION: PHYSIOLOGIC PRINCIPLES AND THEIR CLINICAL APPLICATIONS: by P. H. Rossier, A. A. Buhlmann and K. Wiesinger; edited and translated from German edition by Peter C. Luchsinger, M.D. and Kenneth M. Moser, M.D.; published by C. V. Mosby Co., St. Louis; 505 pages; price $15.75.

This summarizing review of pulmonary pathophysiology was first published in the German language. American translators, in collaboration with the Swiss authors, present this second edition as an international review and compilation.

The book is divided into four parts covering the following general subjects: I. Normal Physiology of Respiration; II. Investigative Methods in Pulmonary Function; III. Pathophysiology of Respiration, and IV. Pulmonary Insufficiency in Clinical Practice. While much of this work pertains to basic pathophysiology and investigative research, the sections on Cor Pulmonale; Specific Pulmonary Diseases, and Influence of Various Nonpulmonary Factors Upon Pulmonary Function will be of interest to the inquiring clinician.

The chapters on cyanosis, dyspnea and pulmonary hypertension are well written and will provide the reader with a clear understanding of the pathophysiology of these important clinical disorders. The section on oxygen therapy is much too brief for the average reader seeking a full discussion.

While the high-tension mathematics used takes this work out of the realm of everyday usage, it should be a valuable reference for those with a particular interest in this field.

An appendix includes many useful tables, equations, and correction factors. An extensive bibliography, covering 80 pages, is provided.

Grover Sanders, M.D.

TEXTBOOK OF OPHTHALMOLOGY; by Francis Heed Adler, M.D.; published by W. B. Saunders Co., Philadelphia; seventh edition, 1962; 560 pages; price, $9.

This is the seventh edition of a textbook designed for the use of the medical student and general practitioner. Doctor Adler, America's outstanding ophthalmic physiologist, has again improved the work by introducing a new chapter devoted to visual and non-visual symptoms. It systematizes thinking along diagnostic ophthalmic lines and is a most handy review chapter.

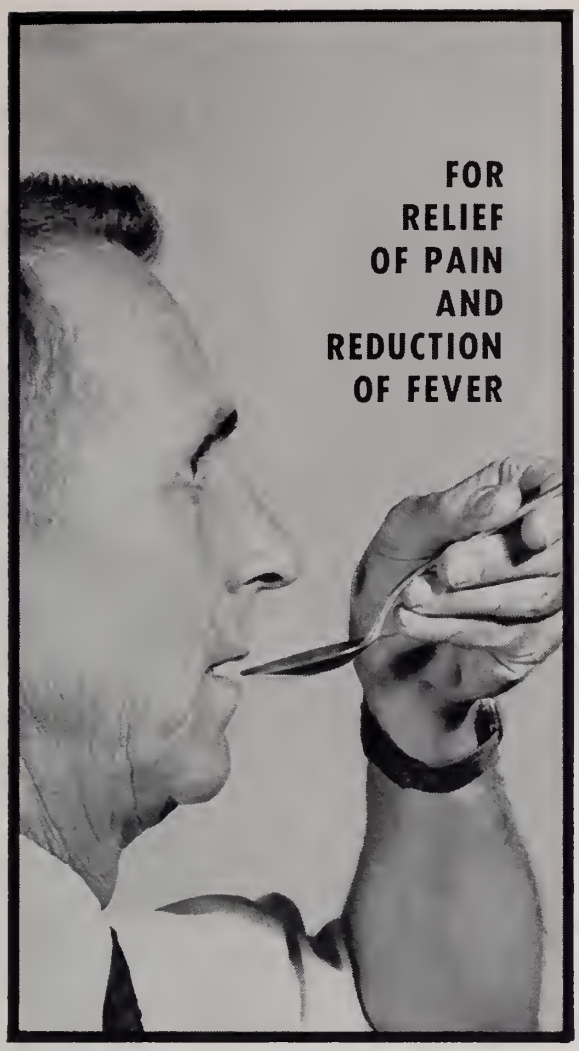
The sections on ocular motility and those on retinal arteriosclerosis and hypertension are especially rewarding. Doctor Adler has a terseness and flare with words that first engages the reader, then stimulates his interest for more. He has infected this text with the same succinctness of form that marks his definitive "Physiology of the Eye". The book deserves careful, thoughtful digestion by every student of the subject in and out of school.

It does, however, suffer from that all too ubiquitous textbook malady, namely, the sections on treatment are, in general, rather incomplete and non-current. Most texts of this type after first reading are as useful as their indices are carefully complete; no problem here. Doctor Adler has again made the road easier for those who follow.

Edward C. Shrader, M.D.

N.Y. Academy Slates Conference

A conference on "Fetal and Infant Liver Function and Structure" will be held at the Henry Hudson Hotel, New York City, November 7-10 under the auspices of the New York Academy of Sciences. Information may be obtained from Mrs. E. T. Minor, executive secretary of the Academy, 2 East 63rd St., New York, 21, N.Y.





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A PALATABLE LIQUID ANALGESIC & ANTIPYRETIC PREPARATION

FEBRO-GESIC is recommended for the relief of pain and reduction of fever in conditions affecting muscles, bones, and joints. Febro-Gesic is further recommended for the symptomatic treatment of upper respiratory infections and many other painful conditions in which the salicylates and other non-narcotic analgesics are commonly used. The liquid preparation is particularly advantageous in patients, such as children, where the administration of tablets is difficult.

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FEBRO-GESIC is supplied in pints or gallons.

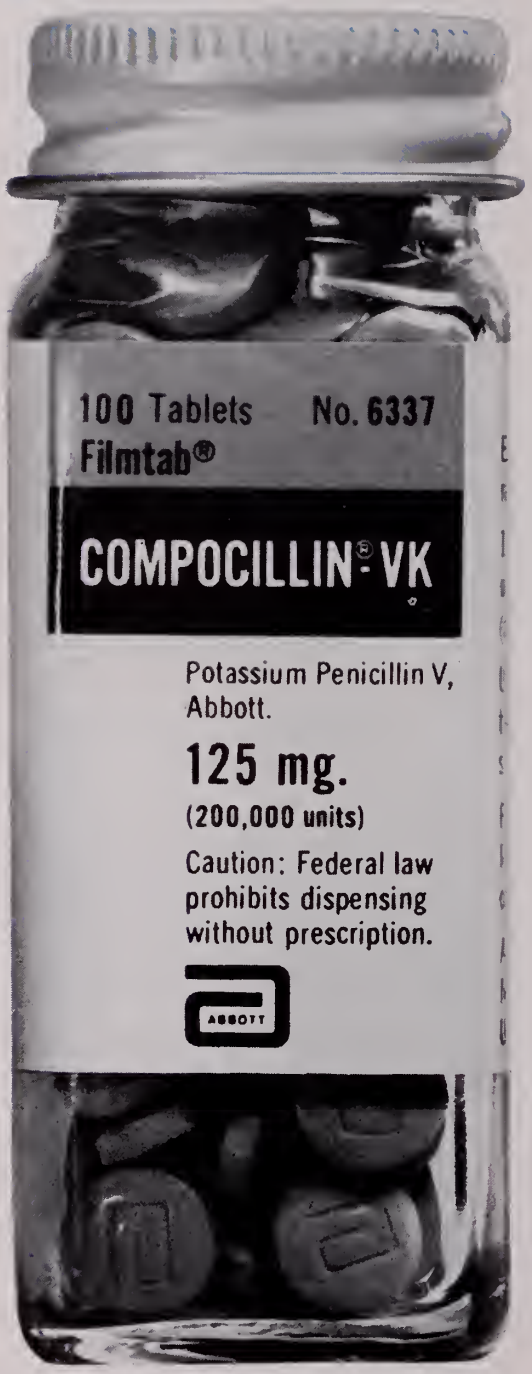
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First Texas *Pharmaceuticals, Inc.*

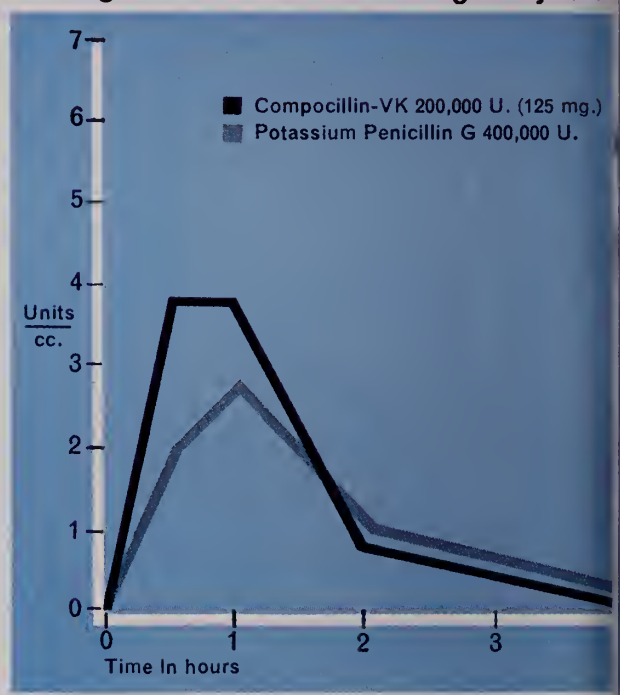
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Consider milder bacterial infectio

An example might be a respiratory infecti Here economy could be a definite factor your thinking. In the chart above, you'll that 200,000 units (125 mg.) of Compocillin V produces blood levels at least equal to th obtained with 400,000 units of oral penicillir potassium. This means that in less severe inf tions, Compocillin-VK may be given at *half* dosage needed with oral penicillin G—with sacrifice in blood levels. In these cases, the c of Compocillin-VK therapy will be no mor and often will be less—than treatment with c penicillin G.

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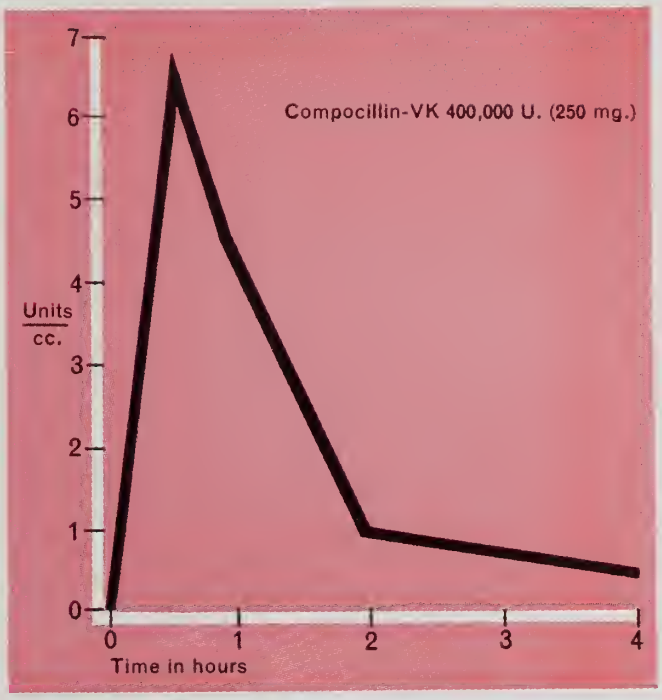
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*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

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ENTOZYME® helps your gallbladder patient digest fat

The gallbladder patient who "can't resist" rich, succulent, greasy foods must often pay for his gastronomical indiscretions with the discomforts of fat-induced indigestion. However, these unpleasant aftereffects can frequently be relieved or prevented with Entozyme, a natural digestive supplement. Six tablets, the usual daily dose, will digest 60 gm. of fat or more. That's 50 to 90 per cent of an adult's normal daily intake. Bile salts stimulate the flow of bile and enhance the lipolytic activity both of Entozyme's Pancreatin and the patient's own lipase. Working together, Bile Salts and Pancreatin greatly aid the emulsification and transport of fat. Each enteric-coated Entozyme tablet contains Bile Salts (150 mg.) and Pancreatin, N.F. (300 mg.). Also 250 mg. of Pepsin, N.F.—enough to digest 8 gm. of protein.

A. H. Robins Company, Inc., Richmond 20, Virginia

WASHINGTON NEWS DIGEST

WASHINGTON, D.C.—Life expectancy at birth reached an estimated 70.2 years in the United States in 1961, according to the Public Health Service.

The estimate was based on a 10% sample of death records received by the National Vital Statistics Division from all the 50 states.

Deaths totaled about 1,702,000 in 1961—a rate of 9.3 per 1,000 population, only slightly higher than the record low rate of 9.2 for 1954.

Some Death Causes Decline

Five of 10 leading causes of death showed sharp rate declines as compared with last year. The declines were large enough to make it improbable that they were produced by normal fluctuations due to sampling. The five were vascular lesions; accidents; influenza and pneumonia, except of newborn; general arteriosclerosis, and diabetes mellitus.

The infant mortality rate of 25.3 per 1,000 live births set a record low, about 2% under the previous low of 25.7 recorded in 1960.

Recent statements that citizens of some foreign countries are healthier than Americans were disputed emphatically by the American Medical Association. The AMA statement was prompted by a paper presented at the recent annual meeting of the American Sociological Association in Washington. The paper said that the United States is not as "healthy" as Sweden and England.

Blasingame's Statement

"This is like trying to compare apples to oranges," F. J. L. Blasingame, M.D., the AMA's executive vice president, said.

"There have been accounts that comparisons of a nation's overall health can be made on the basis of life expectancy—that the people of Sweden and Britain are healthier because they live longer on the average than Americans.

"This proves nothing, for what you are actually comparing are differences in the makeup of populations. Both of these nations have small, stable, homogeneous populations, whereas that of the United States is a vast mixing from practically every conceivable corner of the globe, including all nationalities and races . . .

"What you can prove statistically is that a person of Swedish descent in Minnesota lives longer than a Swede in Sweden, and that Mexicans apparently live longer in New Mexico than they do in Mexico . . .

Auto Accident Deaths

"The death rate from automobile accidents is much higher in the United States than in any European country because a larger percentage of the population own cars. This is a matter of economics and not medicine. Yet auto fatalities are a large factor in reducing this nation's life expectancy."

Doctor Blasingame also pointed out the economic aspect of Americans living at a faster pace, consuming more expensive, fatty foods and dying of heart attacks with much more frequency.

"Communicable diseases, on the other hand, are almost entirely a medical problem and the fact is that the death rate from communicable disease in the United States is well below that of England or Sweden," he said.

Infant Mortality Rates

International statistics on infant mortality rates are meaningless, Doctor Blasingame said, because of different definitions of what is a live birth or a still birth.

"As for insinuations that longer life span and lower infant mortality are somehow linked with the socialized medical practices of England and Sweden, there is absolutely no substantiation," he said. "The rate of increase in longevity in England is no different now than it was prior to the founding of the National Health Service there in 1947 and may actually have declined."

November 11-17 Is Diabetes Detection Week.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 4, 5, 6 and 7, 1963

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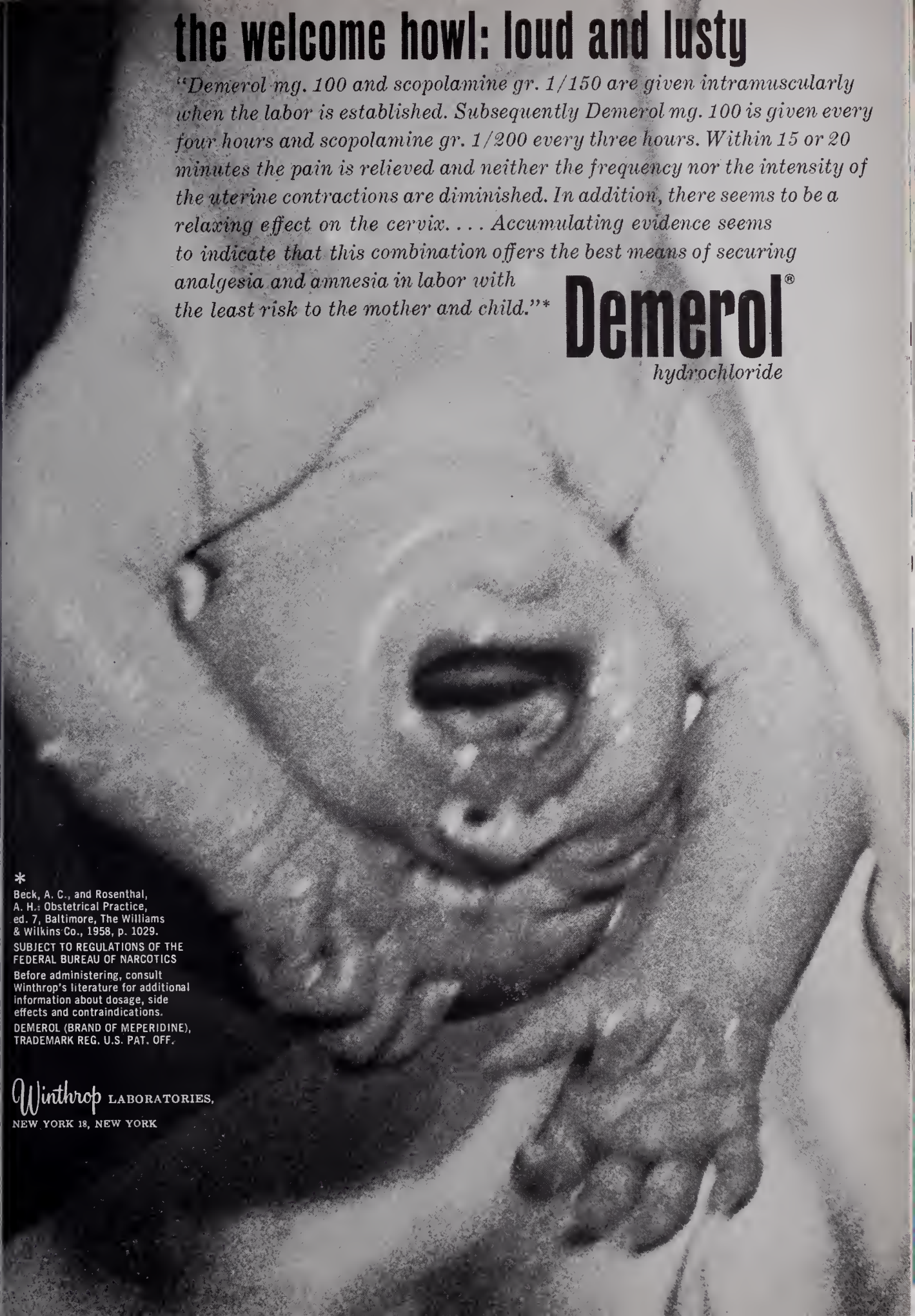
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hydrochloride



*
Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Co., 1958, p. 1029.

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Before administering, consult Winthrop's literature for additional information about dosage, side effects and contraindications.

DEMEROL (BRAND OF MEPERIDINE), TRADEMARK REG. U.S. PAT. OFF.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #124—A 26-year-old, married, white gravida 7 para 6 was first seen on April 16, 1961, one week before her expected date of delivery as calculated from the menstrual history. The diagnosis of term pregnancy complicated by severe toxemia was made, and she was hospitalized immediately.

On admission, the blood pressure was 200/100; there was 4+ pitting edema and 1+ albuminuria. The immediate treatment consisted of the administration of an unstated dose of 20% magnesium sulphate. At 5 p.m. on the day of admission she was having uterine contractions every five minutes lasting 50 seconds. The presenting part remained high over the pelvic inlet; the cervix was three centimeters dilated. The blood pressure was stationary at 200/100. Nothing was known of her previous deliveries.

The membranes ruptured spontaneously at 5:26 p.m., with expulsion of a large amount of clear fluid. The fetal heart sounds were counted at 140 in the left lower quadrant. The patient was transferred from the ward to the labor suite, but when, at 3:15 a.m. on April 17, the contractions became less frequent and of shorter duration, she was retransferred to the ward as not in active labor.

Blood Pressure 150/100

On reaching the ward, her blood pressure was 150/100. The patient was able to take fluids by mouth. On vaginal examination at 9:30 a.m., the cervix was found to be five centimeters dilated. The presenting part was dipping into the pelvic region. Obesity and edema of the abdomen prevented accurate determination of the position and variety. The fetal heart beats were heard in the left lower quadrant and were counted at 144 beats per minute.

During the morning, the uterine contractions became more regular and intense; at 12 noon they were occurring every two or three minutes and lasted 45 seconds. The fetal heart was counted at 148. The patient's temperature at this time was 102° and material passed from the vagina had a foul odor. The blood pressure was now 160/100, and the pulse rate ranged between 100 and 120.

The patient was transferred back to the labor suite and started on penicillin and streptomycin. Active labor continued; she was placed on the delivery table at 2 p.m. and encouraged to "push" with each contraction. At 3:15 p.m. no fetal heartbeat could be heard. Between 3 and 5 p.m., the blood pressure dropped from 160/100 to 80/60, and it was noted that the quality of the uterine contractions became irregular and of short duration.

At 6 p.m., vaginal examination showed a completely dilated cervix with a hydrocephalic head at a −2 station. An external version was done, and a dead hydrocephalic infant with a spina bifida was delivered at 6:08 p.m. No mention was made of the type of anesthesia. The blood loss at the time of delivery was estimated at 100 cc. The postpartum blood pressure gradually dropped to 50/30, though the skin was described as warm and dry.

Soon after the delivery, she vomited an estimated 800 cc. of "coffee ground" material. A medical consultant suggested that she had a gram negative septicemia from the endometritis, together with unexplained bleeding from the gastrointestinal tract. Cutdowns were done on both ankles and the blood pressure was maintained by aramine at a systolic reading of 100 or higher. She also received streptomycin and chloromycetin, whole blood and penicillin. The hematocrit was 38% at 6:30 p.m.; after 350 units of plasma expander and 1,000 cc. of whole blood it was 39%. The systolic blood pressure fluctuated between 105 and 130 with a relatively slow pulse (80-90); the latter became very rapid during the violent episodes of vomiting of "coffee ground" material.

Despite four pints of whole blood, her condition seemed to worsen. She had been on antibiotics for 20 hours, but the temperature was 104.2°. At 9 a.m., the blood pressure was unobtainable. The fluid intake to this point had been 4,200 cc. of 5% dextrose in water and 2,000 cc. of whole blood with a measured output of 2,000 cc. of vomited material and 105 cc. of urine since 3 p.m. on April 17. There had been no urinary output in the last nine hours. The NPN was 31. An electrocardiogram showed only a sinus tachycardia of 160/minute.

On examination, her skin was cold but dry; the lungs were clear; the heart sounds were not abnormal. The abdomen showed generalized tenderness and guarding with the firm fundus felt just above and slightly to the left of the umbilicus. No bowel sounds were audible.

Surgical Consultation

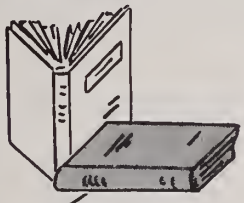
Surgical consultation was obtained, and it was decided that inasmuch as the patient's condition was deteriorating at such a rate that if an overwhelming septicemia was coming from the endometritis, removal of the uterus would at least prevent further infection. The possibility of a ruptured uterus was also considered since the patient's blood pressure dropped some 70-80 mm. during labor.

Under general anesthesia the abdomen was opened in the midline and 1,500-2,000 cc. of old blood were encountered. When this was sucked out, a tear on the right side of the lower third of the uterus was discovered with considerable hemorrhage into the broad

(Continued on Page 1003)

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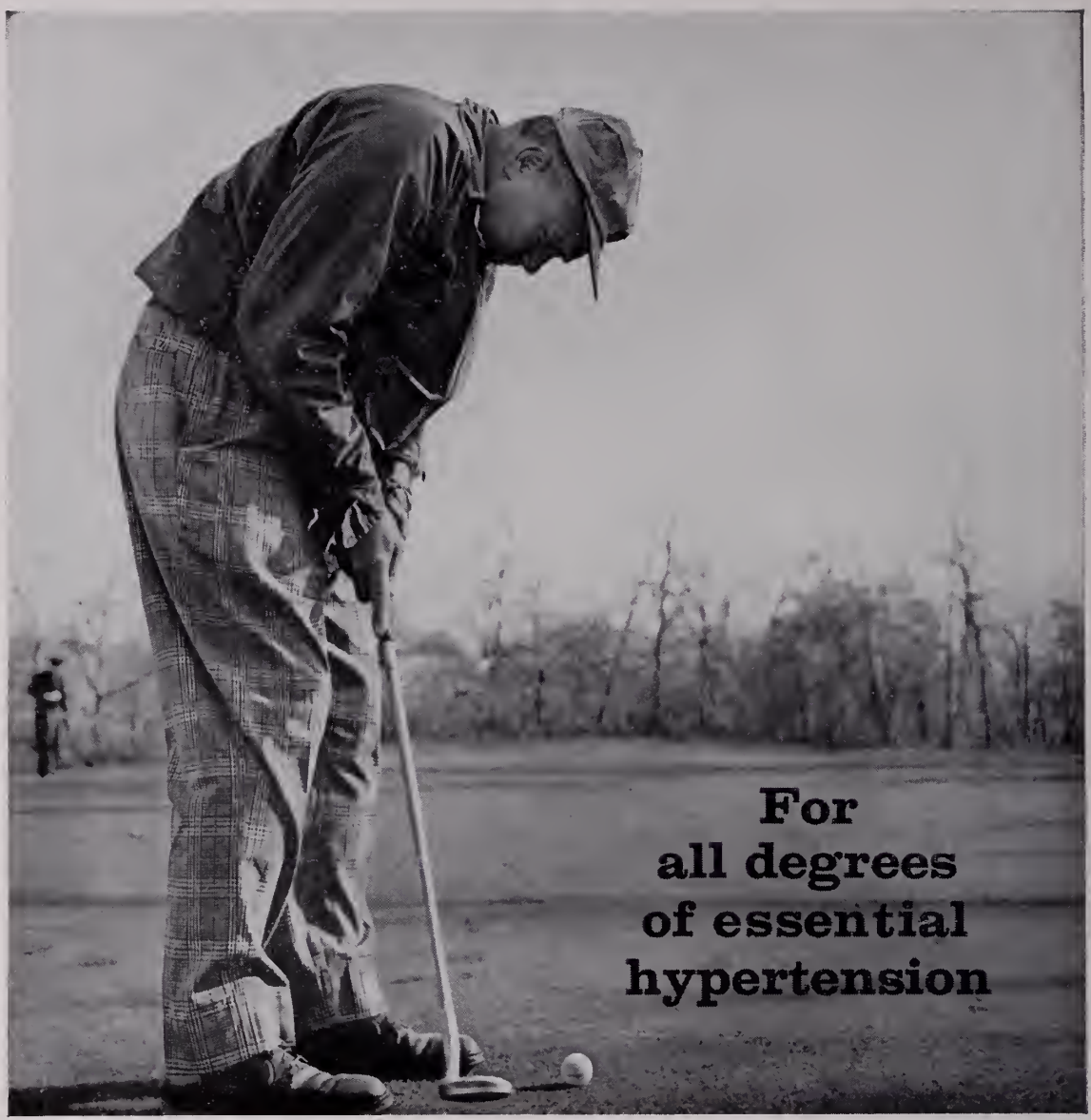
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Maternal Mortality

(Continued from Page 1000)

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The causes of death on the certificate were rupture of the uterus, toxemia of pregnancy and puerperal septicemia.

Comments

The committee considered this case to exemplify a direct obstetrical death with preventable factors on the part of both the patient and the physician.

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Uterine exploration should always be done following any operative delivery; it might well have been lifesaving in this specific case if it had been done.

The Insurance Page

(Continued from Page 934)

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(Ed. note See News Story on Page 977)

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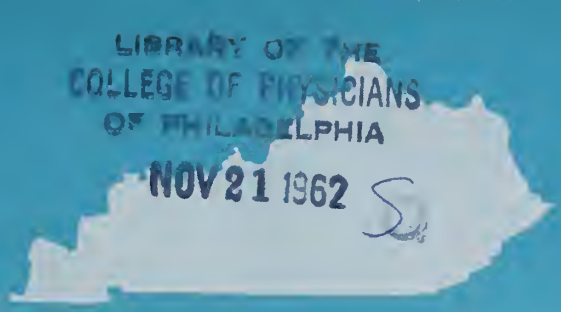
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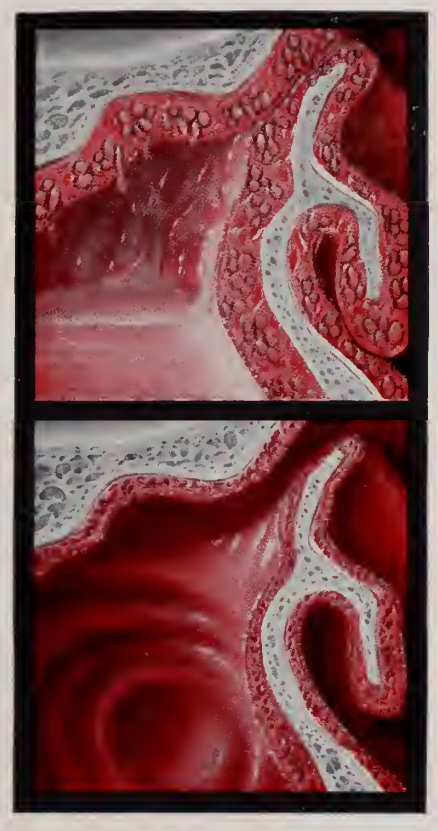
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We have to decide how important we believe it is to save our private enterprise system and our individual freedom. If we see clearly that this is the "contest for keeps" to be decided now, we may determine to prove by resourcefulness and by trial and error, the precepts which are workable and which will save our liberties.

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Freedom is the most worthy objective attainable to man, and, in this time of maximum danger to America, freedom must be made the topic of our conversation, our policy, our plan and the core of our living. With courage and determination and knowledge on our part, the very imminence of the danger becomes an asset, spurring us on in the most vitally important struggle in which Americans have ever been engaged.

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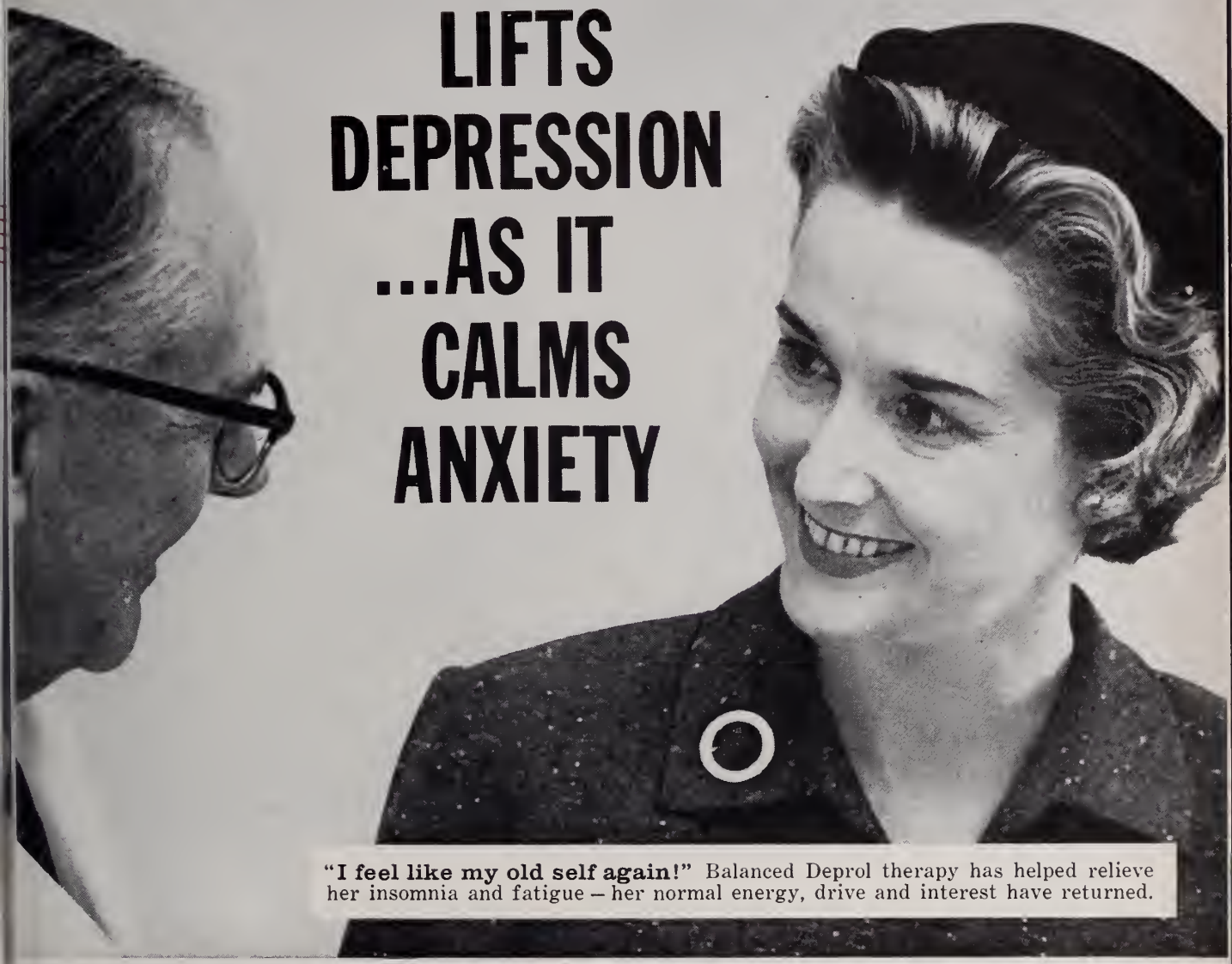
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David M. Cox

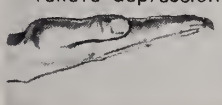
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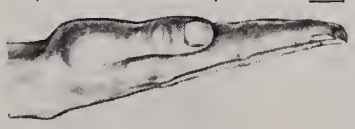




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THE INSURANCE PAGE



Blue Shield Plans Now Have 50,000,000 Members

THE 76 Blue Shield Plans located in North America surpassed the 50,000,000 member mark in their enrollment as of June 30, 1962, the National Association of Blue Shield Plans announced September 25.

Net Gain of 795,160

Total membership in Blue Shield at the end of June reached 50,047,782, as a result of a net gain of 795,160 new members during the second quarter of 1962. The June 1962 figure represents an increase of almost 2,000,000 members over the June 1961 enrollment mark.

Included in the national Blue Shield enrollment figures for the first time during the period were the subscribers of Hospital Care Association, Durham, N.C., and Walla Walla, Wash., Valley Medical Service Corporation. These two organizations were approved as active members of the National Association of Blue Shield Plans in April of this year.

The National Association reported that Blue Shield now covers one out of every four Americans and 15% of the total Canadian population.

Thirteen Blue Shield plans have enrolled more than 40% of the population in the areas they serve. Among them, the District of Columbia Blue Shield Plan has enrolled four out of every five residents in that area; Rhode Island Blue Shield has more than 68% of that State's population covered; Rochester, N.Y., has nearly 66% of its area enrolled; and the Delaware Plan has almost 60% of the State enrolled.

Three Plans Had Record Gains

Three Blue Shield plans registered significant enrollment gains during the second quarter. The Toronto Blue Shield Plan added nearly 90,000 new members during the period; Massachusetts Blue Shield reported a gain of more than 77,000 members, and the New York City Plan registered a 51,000 gain.

The National Association also noted that there were 19,798,391, contracts in force as of June 30 with the number of members per subscriber contract averaging 2.53 members.





Welcome to another year of Lederle Symposia

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 11th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 55,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife for whom a special program is planned.

SANTA BARBARA, CALIFORNIA
Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
Wednesday, November 7, 1962
The Marott Hotel

ANAHEIM, CALIFORNIA
Sunday, November 11, 1962
The Disneyland Hotel

KNOXVILLE, TENNESSEE
Thursday, November 15, 1962
Hotel Andrew Johnson

PHOENIX, ARIZONA
November 18, 1962
Westward Ho Hotel

NEW CITY, NEW YORK
Wednesday, November 28, 1962
Dellwood Country Club

LOS ANGELES, CALIFORNIA
November 29, 1962
Ambassador Hotel

GRAND RAPIDS, MICHIGAN
Saturday, December 1, 1962
Pantlind Hotel

NORFOLK, VIRGINIA
December 6, 1962
Golden Triangle Motor Hotel

DENVER, COLORADO
Sunday, January 13, 1963
The Cosmopolitan Hotel

FORT SMITH, ARKANSAS
Tuesday, January 15, 1963
The Holiday Inn

PORTLAND, OREGON
Thursday, January 31, 1963
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 23, 1963
The Anchorage Westward Hotel

DETROIT, MICHIGAN
Wednesday, February 27, 1963
The Sheraton-Cadillac Hotel

WILMINGTON, DELAWARE
Saturday, March 9, 1963
Delaware Academy of Medicine

HUNTSVILLE, ALABAMA
Thursday, March 14, 1963
The Russel Erskine Hotel

FARGO, NORTH DAKOTA
Saturday, March 16, 1963
The Frederick Martin Hotel
(Moorhead, Minn.)

BELLINGHAM, WASHINGTON
Saturday, March 23, 1963
The Hotel Leopold

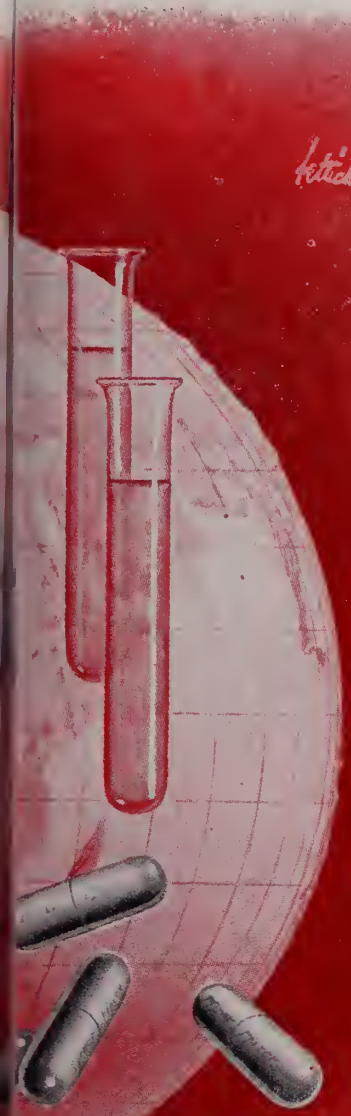
Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



from boutonneuse fever in Africa

Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*

Science for the world's well-being® Pfizer PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York 17, New York



IN BRIEF The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

More detailed professional information available on request.

Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

to bronchopneumonia in Kentucky

BRAND OF OXYTETRACYCLINE

Terramycin® capsules • syrup • pediatric drops
intramuscular solution • intravenous

also available with nystatin as TERRASTATIN® (capsules and oral suspension)

PUBLIC HEALTH PAGE

Modern Nursing Homes: An Adjunct to Medical and Convalescent Care*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE role of nursing homes is gaining significant recognition and is being assigned a prominent place in the fast-moving panorama of medical care. This is evident to anyone who knows what is now available for those willing and able to pay for quality care.

Acceptance Creating Increased Demand

We now have 80 licensed nursing homes in Kentucky, with 3,284 beds located in 29 counties. In addition there are five homes with 380 beds under construction; final plans have been approved for the construction of seven other new homes with 467 beds, and preliminary plans have been approved for 12 more for approximately 800 beds.

In addition, various other groups desire to provide new facilities in various sections of the State. These figures apply to licensed nursing homes only and do not include the licensed rest homes or personal care facilities usually referred to as homes for the aged.

Some Contributing Factors in Acceptance

Not only have acceptable nursing home beds increased in number, but quality of care rendered in existing licensed homes has likewise improved. During the first half of this year alone, 32 additional nursing homes in Kentucky were preparing for listing by the American Hospital Association and of these, nine had been fully approved by Blue Cross for rendering care under their extended benefits program and 16 more were provisionally approved. The staffing pattern in licensed homes is accordingly being improved and demand for the employment of professional help is far exceeding the available supply.

This improvement in turn has led the medical profession to utilize nursing homes to a greater extent for chronic, convalescent and geriatric cases. In view of relatively higher costs in hospitals, the public has appreciated this. Furthermore, the need for most hospitals to employ their beds for use of patients with acute illness, who need the more specialized services which they provide, has brought about greater cooperation between hospitals and nursing homes.

Better equipment and the ability to use it have also been contributing factors. Oxygen equipment and aspirators, as well as fracture frames, overbed pulleys, parallel walking bars, shoulder wheels, chair bikes and numerous other items for rehabilitative and emergency uses are now commonly found in many skilled nursing homes.

Many Services Available

Consultant nutritionists, physical therapists, nurse consultants and consultation on administrative problems are services now available to homes from the State Department of Health. The Department also prepares and makes available such publications as the "Food Service Manual," "Points to Remember in Construction," "Basic Budgeting Procedures," a bi-monthly 12-page bulletin called "Tips and Pointers" and other materials designed to assist administrators in solving their problems.

Another factor of great importance to the improvement of care in nursing homes has been the Nursing Home Association. It has constantly advocated high standards, efficiency, strict enforcement of the licensing laws and regulations and also ethical practices in the relationships of nursing homes with allied agencies, related organizations and the public. From the national level, the Association is pushing toward an accreditation program and in Kentucky, the Association is promoting AHA listing program and qualifications for acceptance by Blue Cross and the medical care program.

Its advisory committee to the State Department of Health assists in and actively promotes the State's plans for improving the quality of care in such homes through workshops, institutes and other methods and programs.

(Continued on Page 1107)

**This article was prepared by Ira O. Wallace, consultant on Nursing Home Administration, Division of Chronic Disease Control, Kentucky State Department of Health, Frankfort, Ky.*



WITH YOUR ENCOURAGEMENT

AND

DEXEDRINE®

brand of dextro amphetamine

SPANSULE®

brand of sustained release capsules

she's losing weight

'Dexedrine' *Spansule* capsules not only control appetite all day long, but at the same time encourage normal activity. This is particularly important because overweight patients are often inactive. In such patients 'Dexedrine' overcomes lethargy, helps renew their interest in doing things—not just eating.

PRESCRIBING INFORMATION

INDICATIONS AND DOSAGE: For the following indications, the recommended daily dosage is one or two 'Dexedrine' *Spansule* capsules, usually taken in the morning: control of appetite in weight reduction; depressive states; alcoholism. In narcolepsy, the recommended daily dosage is up to 50 mg. of 'Dexedrine' by 'Spansule' capsule on arising.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

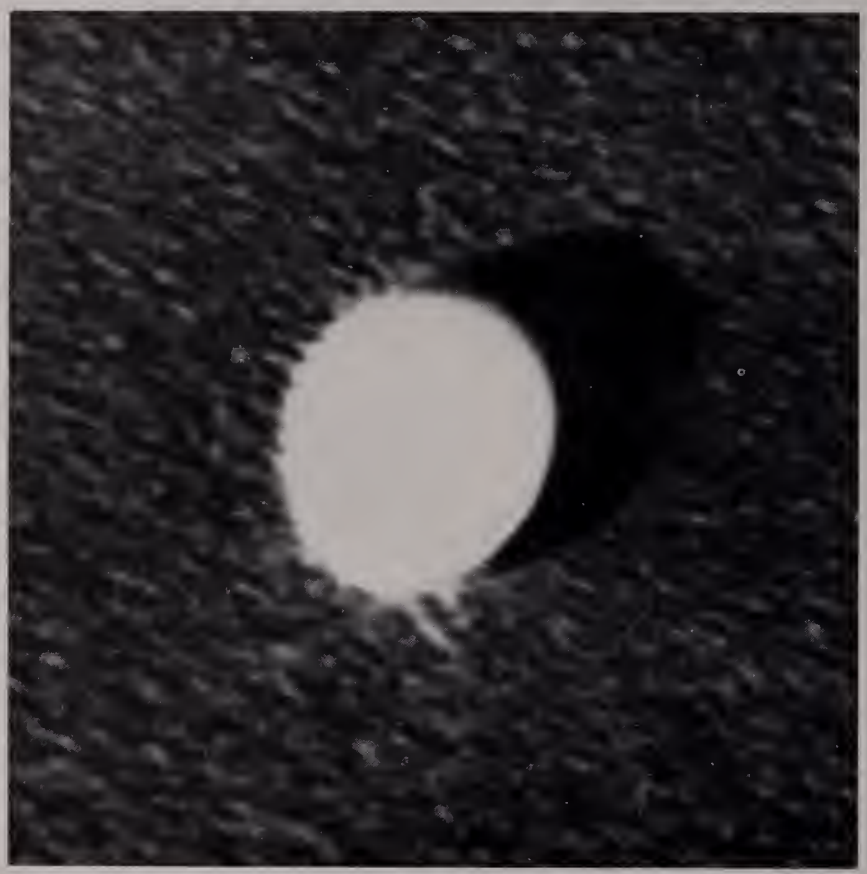
CAUTIONS: Should be used with caution in patients hypersensitive to sympathomimetic compounds; in cases of coronary or cardiovascular disease; and in the presence of severe hypertension.

CONTRAINDICATIONS: Hyperexcitability; agitated pre-psychotic states.

SUPPLIED: 5 mg., 10 mg. and 15 mg., in bottles of 30. (Each capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.)

Prescribing information adopted January 1961.

Smith Kline & French SK&F *Laboratories*





Goliath *David*

Against the formidable and ubiquitous Staphylococcus aureus, PANALBA* gives you a powerful weapon. PANALBA is a selective combination of novobiocin (for its unique effectiveness against staph) and tetracycline (for its breadth of coverage). From the outset, your treatment has broader antibacterial coverage resulting from the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

That is why PANALBA offers excellent chances for therapeutic success.

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who coughed?

HYCOMINE® SYRUP for COUGHS

provides fast and long-lasting cough control

relieves cough in 15-20 minutes • lasts 6 hours or longer • promotes expectoration and decongestion of air passages • rarely constipates • agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE Syrup contains:

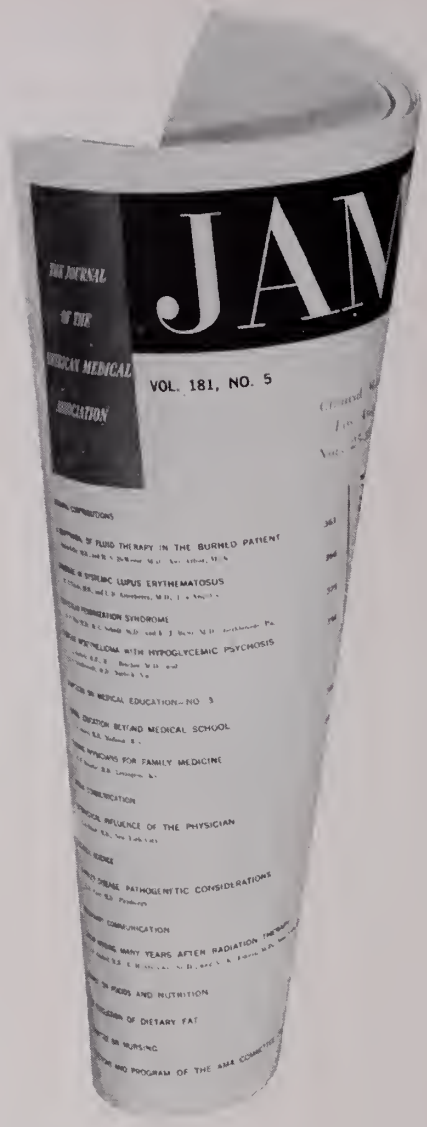
Hycodan®	6.5 mg.
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.
Homatropine Methylbromide	1.5 mg.
Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. On oral prescription where state laws permit. U.S. Pat. 2,630,400.

Literature on request

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Because you are aware of the AMA statement on fat in the diet...

"Increasing the ratio of poly-unsaturated fat to saturated fat in the diet is the preferred method for treating the 'usual' hypercholesteremia."

From the Aug. 4, 1962 issue of The Journal of the American Medical Association.

Of all leading salad and cooking oils Safflower Oil has the highest ratio of poly-unsaturated fat to saturated fat. Safflower Oil is higher in recommended poly-unsaturates—lower in saturated fat than any other readily available oil or shortening.

When an adjustment in dietary ratio of saturated fat is indicated, Saff-o-life

you should be aware of this new, poly-unsaturated oil for cooking

Safflower Oil makes the substitution easy, appetizing, inexpensive.

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to: Professional Services Director, General Mills, Inc., Department 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.

RATIO OF LINOLEATES* TO SATURATES *poly-unsaturated fats

SAFFLOWER OIL	9.0 to 1.0
CORN OIL	5.3 to 1.0
SOYBEAN OIL	3.5 to 1.0
COTTONSEED OIL	2.0 to 1.0
PEANUT OIL	1.6 to 1.0

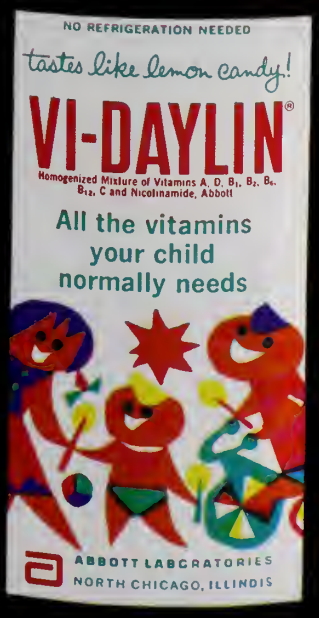
A product of General Mills—Your assurance of quality and purity.



How do the lemons get in the Vi-Daylin?

Perhaps this should be cleared up once and for all. There are *no* lemons in Vi-Daylin. If you've ever tasted Vi-Daylin, this might surprise you. Certainly, it would surprise the youngsters. To most of them, Vi-Daylin is liquid lemon candy, and that's *that*. But if it's deception, it's sensible deception. You never have to badger the kids into taking their vitamins. Nice to know, too, that this matchless matching of candy essence and color elegance can be found in all the forms and formulas of Vi-Daylin.

VI-DAYLIN—Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide, Abbott; VIDAYLIN-M—Homogenized Mixture of Vitamins with Minerals, Abbott; VI-DAYLIN-T—High Potency Multivitamins, Abbott.



Remember, there are *three* liquid formulas: Vi-Daylin, ViDaylin-M® (with minerals), and ViDaylin-T® (therapeutic). And if patients get a little owlly and won't touch *anything* in a spoon, you can give them the new Chewable (please see back of this page).

Each delicious, 5-cc. teaspoonful of Vi-Daylin supplies the following proportions of the Minimum Daily Requirements of:

		MDR (Children)	MDR (Infants)
Vitamin A	0.9 mg. (3000 units)	1	2
Vitamin D	10 mcg. (400 units)	1	1
Thiamine HCl (B_1)	1.5 mg.	2	6
Riboflavin (B_2)	1.2 mg.	1⅓	2
Ascorbic Acid (C)	50 mg.	2½	5
Nicotinamide	10 mg.	1⅓	2

Also supplies cyanocobalamin (B_{12}) 3 mcg. and pyridoxine Hydrochloride 1 mg.

209035A

Abbott Laboratories
North Chicago, Illinois

Gentlemen,

My family enjoys your chewable vitimans. It seems like we can not get enough of your vitimans. My sister enjoys your vitimans so much that she ask for more but cannot have no more. I like them because my mother does not have to worry about scolding us when taking it. Its good because you don't have no worries about something falling on the floor. If you kept on making these vitimans all the worlds children would be happy again. Now I would like to know whether I may have any information on the Middle West. You see my class and I are studying it. So if the information can be given I thank you very much.

"...all the worlds children would be happy again."

(an unsolicited testimonial from an actual letter)



ABBOTT

Logical support for the atherosclerosis diet

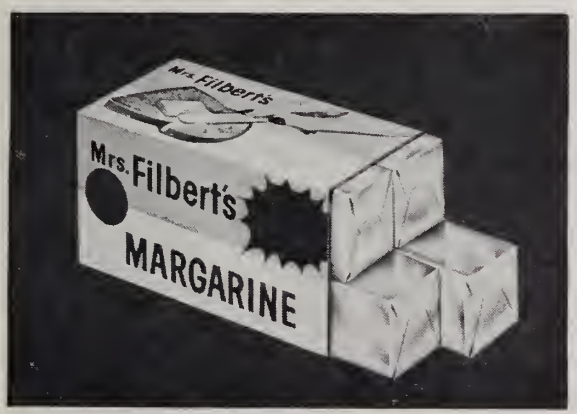
A recent report* in the *JAMA* on atherosclerosis states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, it is in your professional interest to know about the fatty acid composition of the margarines from Mrs. Filbert's.

Each of Mrs. Filbert's Margarines is over 80% unsaturated and offers unique properties useful in the control of serum lipids by dietary means.

Moreover, when you recommend any one of Mrs. Filbert's Margarines, your patient is assured of unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).



Mrs. Filbert's Margarine is a popular, conventional-type margarine with no premium price. It is made from the finest domestic vegetable oils, which are partially hydrogenated for texture, but remain over 80% unsaturated. It has a ratio of polyunsaturates to saturates in excess of 1 to 1. Of the total fatty-acid content, 7% is cis-cis linoleic acid.



Mrs. Filbert's Whipped Margarine contains the same number of calories per pound as ordinary margarine, but contains 30% *fewer calories per pat* because it is whipped. When spread normally, it provides satisfaction with a reduction in fat calories. And its ratio of polyunsaturates to saturates exceeds 1 to 1. Of the total fatty-acid content, 7% is cis-cis linoleic acid.

If you would like information about Mrs. Filbert's family of margarines—including detailed listings of their component characteristics—please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND



Answers To Questions About Your BLUE SHIELD

Q. Does Blue Shield make any allowance for first aid?

A. No allowances for first aid are provided, except where definitive treatment is given. No payment is made for treatment of "minor and insignificant" injuries. Members are not paying for such protection in their dues. However, the Federal Employees Blue Shield Plan provides: "Emergency first aid treatment of accidental injury — when provided within 72 hours after accidental injury and for which no other basic surgical-medical is payable. Maximum payment is $5 on both high and low option plans.

Q. Has Blue Shield made any improvement in the area of in-hospital benefits for medical illness?

A. Yes. There are many different endorsements (riders) available. Groups and members have the right, as Blue Shield is available on a voluntary basis, to choose a plan according to cost and their wishes.

Q. Does Blue Shield—standard or preferred—make an allowance for spinal taps?

A. No, this service is excluded.

Q. It was necessary that a patient of mine, a recent coronary, have his lower teeth removed. Due to his physical condition it was necessary he be admitted to the hospital. An oral surgeon performed the extractions. I attended the patient from a medical standpoint. Will Blue Shield make a payment unthe medical rider to me?

A. Yes. As a doctor of medicine, you would receive the allowance provided by the medical rider.

Q. Are there any waiting periods under the Federal Employee Blue Shield Plans?

A. No.

Q. Does Blue Shield make a payment for assistants in surgery?

A. No.

Q. Why do we have requests from patients for itemized statements from the physician when they have Blue Shield and extended benefits or major medical offered by Blue Cross-Blue Shield?

A. These are required when the patient has extended benefits, supplementary federal employees plan or major medical. These plans have benefits not provided by basic Blue Cross-Blue Shield, and benefits due members can only be determined by itemization of these services.

Q. Standard Blue Shield pays $15 for accident-connected x-rays. Is this $15 per accident or $15 per contract year?

A. Fifteen dollars per accident. X-rays must be taken within 30 days of the accident.

Q. Does Blue Shield make any allowances for operations for deafness?

A. Yes — for such procedures as tympanoplasties and stapes mobilization, except for a pre-existing condition before the waiting period has been satisfied.

Q. Does Blue Shield medical rider pay for medical days on an admission directly related to pregnancy? (Eg. Threatened abortion.)

A. No. This must be considered a part of prenatal care.

in low back pain



Trancogesic helps the whole patient by breaking the triad of pain

The action of Trancogesic is direct and as simple as 1, 2, 3. Its tranquilaxant component—chlormezanone—1. reduces emotional reaction to pain...2. decreases skeletal muscle spasm...and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic treats the *whole* pain complex, helps the *whole* patient—*with unsurpassed safety.*

Each tablet of TRANCOGESIC contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily; the dosage suggested for children from 5 to 12 years is 1 tablet three or four times daily. Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects, and contraindications. WINTHROP LABORATORIES, NEW YORK 18, N. Y.

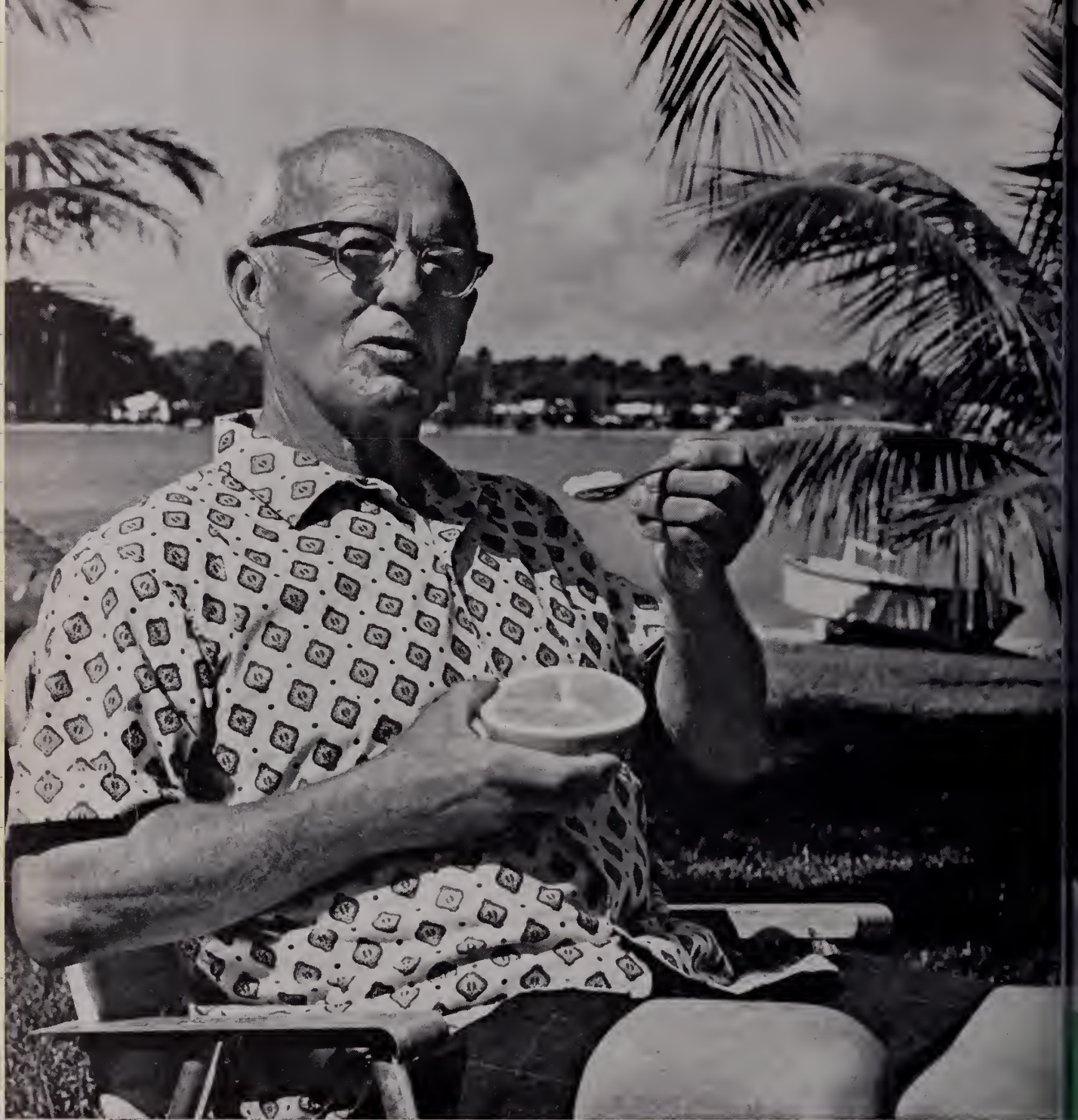
TRANCOGESIC*

Brand of chlormezanone + aspirin

*TRADEMARK

Winthrop

1730M



The good life—just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned or cartoned citrus fruits or juices.

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for more satisfactory relief of anxiety-aggravated pain

PHENAPHEN®

- More satisfactory than "the usual analgesic compounds" for relieving pain and anxiety.[1]
- More effective than a standard A.P.C. preparation for relief of moderate to severe pain.[2]

Each PHENAPHEN *capsule contains:*

Acetylsalicylic acid (2½ gr.)	162 mg.
Phenacetin (3 gr.)	194 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Also available:

PHENAPHEN with CODEINE PHOSPHATE ¼ GR. (16.2 mg.) Phenaphen No. 2

PHENAPHEN with CODEINE PHOSPHATE ½ GR. (32.4 mg.) Phenaphen No. 3

PHENAPHEN with CODEINE PHOSPHATE 1 GR. (64.8 mg.) Phenaphen No. 4

Bottles of 100 and 500 capsules.

1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Making today's medicines with integrity... seeking tomorrow's with persistence.

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TRIPLE SULFA THERAPY is safe at levels of pH 5.5 or lower where the possibility of crystalluria would be greatest.

TRI-AZO-MUL
TRI-AZO-TAB

TRI-AZO-MUL

Each 100 cc contains:

Sulfadiazine (Microcrystalline)	3.381 gm.
Sulfamerazine (Microcrystalline)	3.381 gm.
Sulfamethazine (Microcrystalline)	3.381 gm.

In a palatable, stable emulsion pleasantly flavored with True Raspberry Flavor. Each average teaspoonful (80 min.) represents .5 gm. (7.7 grs.) of three combined sulfa drugs in suspension. Supplied in pint bottles only.

CONTRAINDICATIONS: Sulfonamides are potent drugs, and may cause toxic reactions. Sulfonamides, therefore, should be given only under constant supervision of a Physician.

TRI-AZO-TAB

Each tablet represents:

Sulfadiazine	0.166 gm. (2.57 gr.)
Sulfamerazine	0.166 gm. (2.57 gr.)
Sulfamethazine	0.166 gm. (2.57 gr.)

Available in White or Pink colored tablets in bottles of 100, 500 or 1,000.

TRI-AZO-MUL (citrated) offers the same formula as TRI-AZO-MUL (plain) with sodium citrate (17.5 gm.).

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Pharmaceuticals, Inc.
DALLAS • ATLANTA

Another Established Need Product . . . .

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relieve U.R.I. distress rapidly

- relieve sneezing, runny nose
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- reduce fever, chills

For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

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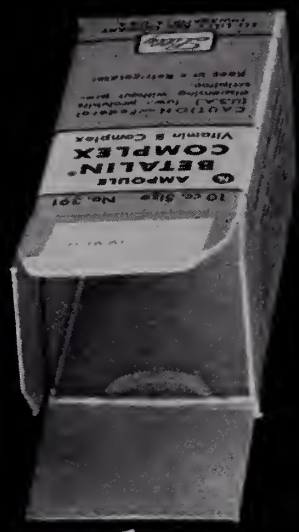
(Brand of Analgesic-Antihistaminic-Antipyretic Compound)

capsules

Each CORIFORTE Capsule contains:

CHLOR-TRIMETON® (brand of chlorpheniramine maleate)	4 mg.
salicylamide	0.19 Gm.
phenacetin	0.13 Gm.
caffeine	30 mg.
methamphetamine hydrochloride	1.25 mg.
ascorbic acid	50 mg.

available on prescription only



the case of the missing ampoule

People aren't perfect—neither are machines. Both can slip up occasionally. Take an ampoule in a paper carton for example. How can we be absolutely sure that the ampoule is really inside? ■ Here's how: A machine folds the carton, inserts the ampoule, seals the carton, and then places it on the finishing line. Further down the line, the detective waits—a jet of air sweeping across the finishing line just strong enough to blow an empty carton off the belt. Properly filled cartons proceed for further inspection and packaging. ■ Perhaps a small point, but it is another in a long series of control measures designed to deliver quality pharmaceuticals every time.

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Lilly

290326

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 60 NOVEMBER, 1962 No. 11

Results in the Radiotherapeutic Management of Carcinoma of the Uterine Cervix

RALPH M. SCOTT, M.D.*

BILLY WELLS, M.D.

Louisville, Ky.

The cure rates achieved and the associated low incidence of serious complications in the radiotherapeutic management of invasive carcinoma of the uterine cervix remain impressive. Radioresistant carcinoma of the cervix is rare.

CANCER of the uterine cervix was the first of the internal cancers to be treated successfully by irradiation. The early adaptations of radium and x-rays to the treatment of this disease gained radiotherapy its first recognition as an important contributor to cancer therapy. From its beginning to the present the effectiveness of this modality of treatment of cervical cancer has demonstrated its superiority.

Value of Radical Surgery

Periodically efforts are made to assess the value of radical surgery in this disease and recent advances in anesthesia and antibiotic therapy add impetus to these. With early cases, in the hands of experienced surgeons, curative results are possible which can be more easily and safely obtained with radium and x-rays. Stage 0 carcinoma of the cervix is a surgical problem, but the results obtained by surgery in Stage I through Stage IV have not displaced radiotherapy as the treatment of choice.

Although the results to be expected from radiation therapy are well established, figures from small centers seem worthy of presentation. With proper understanding of the principles of treatment satisfactory results are not limited to the larger institutions.

Case Material

The following case material represents the Stage I through Stage IV cases treated primarily by radiation at the Louisville General Hospital over a 10-year period from July 1946 through July 1956. Cases primarily treated surgically or with combinations of radiotherapy and surgery and cases treated elsewhere and coming here for further treatment are excluded. Until recent years many cases fell into these two categories. There are 109 patients in this series.

The material is not unique. Medically indigent cases comprise the vast majority of the group. The patients range from 27 to 80 years of age with the peak incidence between 40 and 50. Of the 109 cases, 44 were Caucasian and 65 Negroes.

The number of cases in each individual clinical stage is remarkably equal. When our series is compared with the figures from the Seventh Annual International Report,[1] which corresponds most closely with the years covered by this study, it is seen that we have more Stage I cases than might be anticipated and also more Stage IV cases. (Figure I) (See next page.) This may be coincidental with our small series, but the effect on cure rate could be profoundly altered if these did not tend to cancel each other.

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Figure I

Clinical Stage	LGH % of Total	7th Annual Int. Report % of Total
I	26.7	16.4
II	29.3	36.1
III	25.7	35.7
IV	18.3	11.7

Generally these patients were admitted, studied and staged by the Gynecology Department. All possible attempts were made to improve their general condition, such as correction of anemia, elimination of infection and improvement of nutritional status. The Radiology Department assumed the responsibility for radiation therapy and care during treatment. Following this they were followed jointly by the two Departments.

The techniques of radiation have varied over the years depending upon the individual case and the radiotherapist in charge. The majority were treated with some combination of intracavitary radium and conventional deep x-ray therapy, but practically all modalities of irradiation have been employed, including transvaginal. A cobalt 60 teletherapy machine was installed in this hospital in 1954 and from that time on most cases were treated with this unit combined with intracavitary radium or transvaginal irradiation.

Our criterion for "cure" is a patient alive without evidence of recurrence five years after treatment. Patients lost to follow-up or dead of intercurrent disease before five years are considered failures. Figure 2 shows the results of treatment according to stage and method of treatment. The number treated by any given method is too small to permit any significant analysis of the relative effectiveness of any one method. Nevertheless, certain impressions emerge from a study of this table.

First, the number of modalities employed attests to the individualization of treatment given each case. In addition, radium alone can be very effective in controlling early disease (four cures out of four so treated). Little difference is noted between the results with the combinations of radium and conventional deep x-ray (28 cures out of 51 cases) and radium with telecobalt therapy (7 cures out of 14 cases). External irradiation alone, either with conventional deep x-ray or telecobalt, was used main-

Figure II

RESULTS WITH DIFFERENT MODALITIES OF TREATMENT

TREATMENT	STAGE I	STAGE II	STAGE III	STAGE IV	ALL STAGES
RADIUM	TREATED 4 CURED 4				TREATED 4 CURED 4
RADIUM + CONVENTIONAL DEEP X-RAY THERAPY	TREATED 19 CURED 16 RECURRED 3	TREATED 18 CURED 9 RECURRED 9	TREATED 10 CURED 3 RECURRED 7	TREATED 4 CURED 0 RECURRED 4	TREATED 51 CURED 28 RECURRED 23
RADIUM + COBALT 60 TELETHERAPY	TREATED 3 CURED 3	TREATED 7 CURED 3 RECURRED 4	TREATED 3 CURED 1 RECURRED 2	TREATED 1 CURED 0 RECURRED 1	TREATED 14 CURED 7 RECURRED 7
RADIUM CONVENTIONAL DEEP X-RAY & COBALT 60 TELETHERAPY	TREATED 0	TREATED 3 CURED 1 RECURRED 2	TREATED 1 CURED 1	TREATED 1 CURED 0 RECURRED 1	TREATED 5 CURED 2 RECURRED 3
CONVENTIONAL DEEP X-RAY THERAPY ONLY	TREATED 1 CURED 0 RECURRED 1	TREATED 1 CURED 1	TREATED 10 CURED 2 RECURRED 8	TREATED 12 CURED 2 RECURRED 10	TREATED 24 CURED 5 RECURRED 19
COBALT 60 TELETHERAPY ONLY	TREATED 1 CURED 1	TREATED 2 CURED 2	TREATED 3 CURED 0 RECURRED 3	TREATED 2 CURED 0 RECURRED 2	TREATED 8 CURED 3 RECURRED 5
TRANSVAGINAL X-IRRADIATION + COBALT 60 TELETHERAPY	TREATED 1 CURED 1	TREATED 1 CURED 0 RECURRED 1	TREATED 1 CURED 1	TREATED 0	TREATED 3 CURED 2 RECURRED 1
TOTAL TREATED	29	32	28	20	109
TOTAL CURES	25	16	8	2	51
PER CENT CURES	86.6	50	28.5	10	46.6

Figure III

Clinical Stage	I	II	III	IV	All Stages
ACS Report Five-Year Survival Rate	70.1%	48.6%	25.9%	8.7%	35.5%
LGH Five-Year Cure Rate	86.6%	50%	28.5%	10%	46.6%

ly in late stage disease with palliation in mind. The fact that occasional cures were obtained in this manner indicates the vulnerability of this disease to irradiation.

The overall and stage by stage cure rates in this series compare very favorably with most published results. James,[2] in a recent publication of the American Cancer Society, compiled figures from the world literature from 1953 to 1957. A total of 13,247 cases was evaluated. An absolute five-year survival rate of 35.5% was given for this group. Of the Stage I cases, 70.1% survived for five years; Stage II 48.6%; Stage III 25.9% and Stage IV 8.7%. Figure 3 compares these figures with the LGH series.

Complications

A consideration of the complications resulting from irradiation for this disease is fully as pertinent as consideration of the cure rates. Vaginal shortening and vaginal adhesion formation have been very common in this series. This is of consequence in the sexually active patients and can be avoided to a large extent by good vaginal hygiene and early, continued dilatation after treatment. The fact that it has occurred so frequently is disappointing.

Subcutaneous fibrosis in the fields of external irradiation has been seen in a few patients treated with cobalt 60 irradiation, but this has not been common. Its occurrence in a few cases and not in others is difficult to explain since the treatment factors have remained fairly constant. No hip fractures were encountered. Six of the patients living five years without evidence of cancer developed localized areas of necrosis in the vagina or cervix and five of these healed with conservative treatment. One necessitated hysterectomy.

The most dreaded complication is fistula formation. Three of our cases developed recto-vaginal fistulae. One of these died of cancer and the other two are living without evidence of cancer. No vesico-vaginal fistulae were encountered in the series. Four of the survivals have complained of intermittent episodes of urinary frequency and two have radiation proctitis which has occasionally bled. One patient required surgery for rectal stricture. This group of complications does not seem too high a price to pay for the cures obtained and compares very favorably with the complication rates in most published surgical series.

Causes of Failure to Cure

Many believe that certain carcinomas of the cervix are radioresistant and that this is a major cause of treatment failures in the early stage cases. Examination of our failures tends to refute this. Of the four failures in Stage I, three received inadequate radium therapy, leaving only one failure in a case which was completely treated.

Sixteen failures occurred in Stage II cases. One of these was well three years and then lost to follow-up and for this reason considered a failure. In five other cases treatment was inadequate for various reasons. Another died of pulmonary metastasis with no evidence of the disease in the pelvis. Thus, only 1 of 29 Stage I cases and 9 of 32 Stage II cases which were adequately treated failed to result in cure and mistakes in clinical staging undoubtedly account for some of these. This would not tend to indicate a significant number of radioresistant cases.

Conclusions

The results of 109 cases of carcinoma of the cervix managed by radio-therapy are examined. This treatment gives cure rates which are as good and complication rates which are as low as any other method available today. The incidence of radioresistant carcinoma of the cervix, if it truly exists, is low.

References

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2. James, A. G., Cancer Prognosis Manual (1961). American Cancer Society Inc. publication.

Discriminating Use of Endocrine Tests*

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Practical methods of estimating the function of most endocrine glands are presented. When the history and physical examination are suggestive, such tests, discriminatingly used, help diagnose many endocrine diseases.

THERE is at present no group of simple screening procedures for easy diagnosis of all endocrinopathies. Some assays of endocrine functions, such as testing the urine and the blood for glucose, are simple enough to become routine on all patients. Such tests do not make the diagnosis, but with other indications from the patient's history and physical examination, help to determine the need for more discriminating procedures.

The purposes of this paper are to present practical methods of assaying the various endocrine glands, and to show how we may use them in diagnosing some of the endocrine diseases. Diabetes mellitus, aldosteronism and thyroid disease will not be discussed here.

In general, it is wise to remember that the endocrine glands have great reserve capacity, so that generalized involvement of such a gland may be necessary before hypofunction is obvious. Conversely, very small areas of hyperfunctioning endocrine tissue may produce startling, even fatal reactions. In overfunctioning endocrines, the output may be erratic, and tests taken when the overfunctioning tissue is at rest may be normal. For these reasons, many of the assays now used attempt either to measure the reserve of the organ, or to stimulate its function. Many such tests are necessarily indirect, since assays of many of the hormones themselves are elaborate, being useful more for investigative research than for clinical diagnosis.

Evidence of hypersecretion of a hormone does not necessarily mean abnormality of the gland secreting that hormone, since the defect may be due to excess stimulation from higher centers, from other endocrine glands, or as a homeostatic mechanism in non hormonal disease. Similarly, hyposecretion does not always mean the gland responsible for the undersecreted hormone is diseased, but may be due to lack of trophic hormone or other stimuli to that gland, or due to malnutrition. Finally, one must lay to rest the frequent assumption that tumors, especially malignant tumors, of endocrine glands can be diagnosed because such tumors will fail to be controlled by trophic hormones. Unquestionably, this is often true, but by no means always, and when the criterion to rule out malignancy is solely response to trophic hormone, great danger exists of missing the operable malignancy.

In a crude way, Figure 1 illustrates the interdependence of the brain, pituitary gland, target glands and body tissues, and the various routes through which hormones act and hormonal output is controlled. In selecting tests for measuring hormonal production, we must take all these intrafunctions into consideration. Sometimes, we are able to measure directly in the

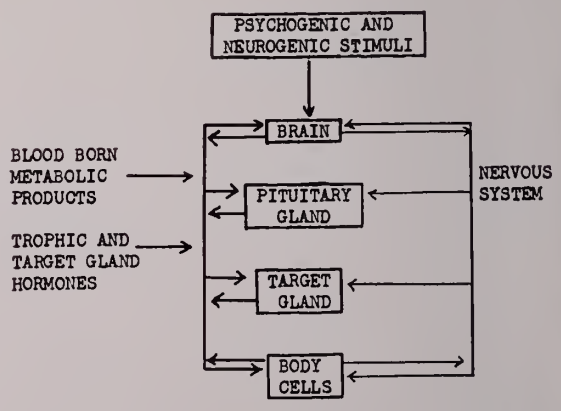


Figure 1. Stimuli affecting the endocrines, and interdependence of system.

Lecture at Postgraduate Course on Endocrine Disorders, January 25, 1962, at the University of Kentucky Medical Center, Lexington, Ky.

blood the particular hormone in question, such as hydrocortisone; or measure its end-products in the urine, such as vanillyl-mandelic acid, the end-product of epinephrine and norepinephrine. In other cases, the effects on blood or other body fluid constituents may be useful indices of endocrine function; for example, blood and urinary glucose in diabetes mellitus. Direct tissue effects, such as vaginal spreads and bone changes seen by X-ray, may be used as indices of endocrine function. We may stimulate the gland, as with available trophic hormones, or attempt to depress the production of trophic hormones through feed-back mechanisms.

Pituitary Gland

Lying as it does in a bone-restricted area, overgrowth of the pituitary gland may result in overproduction of some hormones, only to crowd other hormone-producing areas. Such growth may lead to depression of all, or nearly all hormone production by the gland. Rarely, a pituitary tumor occurs without endocrine disturbance. Panhypopituitarism, whether from tumor or infarction, may be associated with all types of combinations of defects, depending upon which functions are lost. Many of the pituitary hormones are trophic hormones to other endocrine glands and will be discussed along with their respective target glands.

Growth Hormone

Gigantism and acromegaly are associated with excess production of somatotrophin (growth hormone). When these diseases are suspected, our first laboratory tests would be for glucose intolerance, x-ray study of the sella turcica, and x-ray studies for bone age and other signs of excess somatotrophin. Fasting serum phosphorus levels are useful, since they parallel the degree of activity. Early in these diseases, excretion of follicle stimulating hormone (FSH) is apt to be elevated; later, the opposite is true. However, before obtaining this assay, the answer may be available from evidence of target gland function, as we shall discuss later. During the active state, the basal metabolic rate may be slightly elevated, as may the 17 ketosteroid excretion.

Decreased production of somatotrophin is found in pituitary dwarfs, as well as burned-out gigantism and acromegaly. The laboratory diagnosis of pituitary dwarfism starts with roentgenograms of the skull, which may show either an enlarged or a small, bridged sella turcica. X-rays for bone age will show retardation. Hypoglycemia may be present, and the glucose tolerance test may be low and flat. The basal metabolic rate, protein bound iodine, and radioactive iodine uptake may be slightly lowered. FSH and 17 ketosteroid excretion may be low.

Pituitary dwarfism is separated from hypothyroid dwarfism by: sella changes, when present; the smaller degree of thyroid depression, which responds to repeated thyroid-stimulating hormone stimulation, and the low FSH and 17 ketosteroid excretion.

The girl with ovarian agenesis may have slightly retarded bone age; but, due to lack of gonadal hormone, shows osteoporosis and marked elevation of FSH. In dwarfism associated with sexual precocity, bone age is markedly advanced, and the 17 ketosteroid excretion is high. The achondroplastic dwarf may have specific bone changes on roentgenograms, while the renal dwarf shows BUN elevation. Primordial dwarfs show no laboratory changes.

When decreased somatotrophin is part of the picture of Simmond's disease, there may be in addition evidence of adrenal, thyroid and gonadal failure.

Diabetes Insipidus

The principal disease associated with abnormality of the posterior pituitary gland is diabetes insipidus, which may occur by itself, or in association with disease of the anterior pituitary. The posterior pituitary does not of itself form any hormones, but serves as a depot for vasopressin and oxytocin from the supraoptic nucleus.

When polyuria exists, the diagnosis of diabetes mellitus does not rule out diabetes insipidus, unless the polyuria ceases with the control of the diabetes mellitus. If severe renal disease is ruled out, further tests are necessary. Urine volumes and specific gravity should be checked, before and after water loading. Water deprivation tests may be diagnostic, but are dangerous, and should not be used. Skull x-rays may show abnormality of the sella turcica or evidence of xanthomatosis.

The Carter-Robbins urinary excretion test[1] is diagnostic. Patients with psychogenic polydipsia will show prompt diminution in renal

flow with intravenous hypertonic saline; those with diabetes insipidus will not respond until after Pitressin® is given; and those with renal disease will not respond to either. Polyuria and polydipsia can also occur with hyperparathyroidism. The underlying cause of pituitary failure must always be determined and treated if possible.

Hyperparathyroidism may be due to hyperplasia or, more commonly, tumor. Hypoparathyroidism most commonly is from accidental removal of the parathyroid gland during thyroidectomy. Pseudohypoparathyroidism is due to an end organ defect, with lack of response of the renal tubules to the hormone.

In this part of Kentucky, the common occurrence of calcium-containing renal calculi is the most frequent sign prompting investigation for hyperparathyroidism. Other diseases which may need to be differentiated by laboratory means are malignant metastases to bone; sarcoidosis; acute immobilization osteoporosis; Vitamin D intoxication; and Burnett's syndrome, due to chronic ingestion of milk and soluble alkali. In this latter case, we must remember the reports of patients with parathyroid tumors and peptic ulcers.[2] We may see in the same patient true hyperparathyroidism and the milk-alkali syndrome.

In hyperparathyroidism, the Sulkowitch test[3] is strongly positive, unless renal failure is present. Reynolds' group[4] has recently evaluated phosphate excretion tests in the diagnosis of hyperparathyroidism and supports the general view that serum calcium determinations are probably adequate screening tests for hyperparathyroidism. The presence of abnormal levels of serum proteins, causing abnormal amounts of calcium to be bound, may lead to false interpretations of this test, since it is the ionizable calcium level that is important in parathyroid disease. Ionizable calcium levels can be calculated with reasonable clinical accuracy from measurements of the total serum calcium and protein, using a simple graph (Figure 2). Ionizable calcium levels above 5.25 mgm/100 ml are significant. This would approximately equal a serum calcium of 10.5 mgm/100 ml when the total serum protein is 6 gm/100 ml. If there is any question, the serum calcium determinations should be repeated. If the results are borderline, specimens

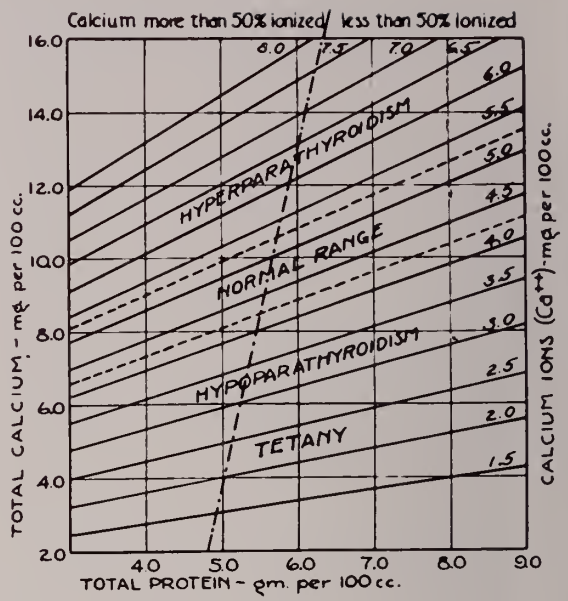


Figure 2. Graph for Calculating the Ionizable Calcium from Total Serum Protein and Serum Calcium. (From McLean and Hastings, Am. J. M. Sc. 189:601, 1935.)

should be sent to other laboratories. One should choose those laboratories doing serum calcium analyses frequently, with reproducible results.

The Department of Medicine at the University of Kentucky Medical School has been testing methods for accurate assays of serum calcium and believes it has an extremely accurate and reproducible method, which takes less than a minute to perform. It is outlined as follows:

Reagents:
a. 0.09 N NaOH (1:200 dilution of carbonate free saturated NaOH).
b. 40 mgm% Calcon, aqueous. Aged two days, stable one month.
c. 10 mgm% EDTA (2.5×10^{-3} molar) aqueous.

Procedure:
a. In a 10 ml beaker, place 0.5 ml serum.
b. Add 5.0 ml of 0.09 N NaOH.
c. Add 1 drop Calcon Indicator.
d. Titrate with EDTA, using a microburette. Stir constantly with magnetic stirrer.
e. End-point. — Loss of red color. Note: A blue color may appear at the end, but this is not end-point. Loss of red color is end-point.

Calculation: ml of EDTA x 20 = mgm/100 ml Calcium (x10 = mEq/liter).

In hyperparathyroidism the *fasting* serum phosphate level is depressed, unless renal disease has impaired excretion of phosphorus. When the serum phosphorus level is depressed, it is a most reliable evidence of this disease.

When bone changes occur in hyperparathyroidism, the serum alkaline phosphatase is elevated. Dental x-rays may show the absence of the lamina dura, as well as bone cysts. Other roentgenographic studies may show nephrocalcinosis and bone effects.

Urinalysis may show signs of renal lithiasis or infection, and the specific gravity may be low. Occasionally, Bence-Jones proteinuria is present. Signs of renal failure may occur, with elevated BUN and decreased renal function tests such as the PSP.

Excessive use of Vitamin D is distinguished by increased serum and urine calcium and phosphorus levels. Elevated serum calcium levels as a result of hormonal treatment of malignancy may be explained in the history. In multiple myeloma and sarcoid the serum calcium level is elevated, but so, too, is the total serum protein, so that the ionizable calcium is usually normal. Increased serum calcium can occur with immobilization and increased calcium intake.

Calcium Tolerance Test

When there is still a question as to the diagnosis of hyperparathyroidism, the calcium tolerance test of John Eager Howard[5] may be useful.

The milk-alkali syndrome may be very difficult to differentiate from hyperparathyroidism when renal damage has occurred. The former is usually characterized by hypercalcemia with hypercalciuria or hypophosphatemia, plus renal insufficiency. If there is not a fairly rapid return towards normal after the discontinuance of milk and soluble alkali, it may still be necessary to rule out a parathyroid adenoma.

When renal tubular disease causes lowering of phosphorus, the serum calcium is low to normal until nephrocalcinosis occurs, after which the serum calcium may be elevated and make the differential diagnosis difficult. Usually, however, the history of renal disease antedates the nephrocalcinosis.

Hypoparathyroidism

The most significant laboratory finding in hypoparathyroidism is the lowering of the serum ionizable calcium below 4.25mgm/100 ml. Here, again, serum total proteins should be measured on the same sample of blood that is used for the total serum calcium determination, although in tetany the total calcium may be so low as to leave no question. Unless the urine is highly concentrated, or the patient is on a high calcium diet, the Sulkowitch test will be no higher than 1 plus. The serum phosphorus level is elevated.

Tetany from inadequate absorption of calcium from the intestine is usually differentiated by its accompaniment with hypophosphatemia, as in rickets and osteomalacia. Steatorrhea will occasionally be so occult as to require special tests for diagnosis, but also is associated with hypophosphatemia. Alkalotic tetany is associated with a normal urine Sulkowitch test, normal serum calcium and phosphorus, and laboratory evidence of alkalosis. Serum phosphorus may be elevated in kidney disease and be associated with tetany, but the BUN will be elevated, along with other signs of renal disease antedating the tetany.

Pseudohypoparathyroidism can be differentiated by the Ellsworth-Howard test, using parathyroid extract.[6]

The Sulkowitch test finds its greatest usefulness in adjusting the therapy of hypoparathyroidism, the aim to maintain a 2 to 3 plus reaction.

Insulinoma and Hypoglycemia

The most useful single test for insulinoma is the fasting blood sugar determination, especially if taken during a convulsion. Hypoglycemias from other causes are relatively easy to differentiate. The standard oral glucose tolerance test, continued for four or five hours if necessary, is of value. Insulinomas characteristically cause the initial blood sugar to be below normal, which then rises no higher at peak levels than 120 mgm/100 ml, drops from this peak to lower levels, which fail to rise as long as fasting is continued. Alimentary hypoglycemia, in this test, causes a normal peak blood sugar, followed by subnormal levels which return to normal as the fast continues. In Addison's disease and malabsorption syn-

dromes the curve is flat, but in malabsorption the intravenous glucose tolerance may be normal, or even suggest diabetes.

If the fasting blood sugar is normal and yet the diagnosis is suspected, the old three-day fast can be avoided by using the intravenous sodium tolbutamide test[7]:

1. Patient eats a high-carbohydrate diet for three days.
2. One gram sodium tolbutamide in 10 ml distilled water is given intravenously in two minutes.
3. Blood sugars are tested every 15 minutes for three hours. Terminate test with oral or intravenous glucose if severe hypoglycemic reaction occurs.
4. Interpretation: Positive for insulinoma = 40% or more drop, and most significantly blood sugar stays low for rest of three-hour period. Normal subjects drop less than 40% and return to normal levels quickly.

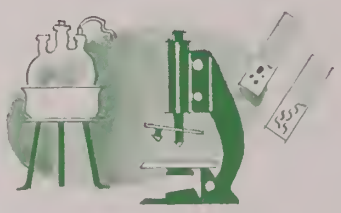
Another test uses glucagon intravenously[8]:

1. Six- to eight-hour fast.
2. One mgm glucagon intravenously in four minutes.
3. Interpretation: Normally blood sugar rises and returns to normal as in glucose tolerance test. Patients with insulinomas have same initial rise, with a fall to hypoglycemic levels in two to two and one-half hours.

In infants, idiopathic spontaneous hypoglycemia may occur. At least some of these are leucine sensitive, and may become severely hypoglycemic after meals, even to convulsive levels. This can be tested with 1. leucine given orally or intravenously[9]:

1. 150 mgm 1. leucine/Kg body weight given orally or intravenously.
2. Blood sugar taken every five to ten minutes.
3. Interpretation: With leucine sensitivity, blood sugar falls to hypoglycemic levels in 10 to 20 minutes. Other members of family without the disease may have milder responses. Some patients with insulinomas respond similarly until tumor is removed.

(To be continued in The December Journal)



Parathyroid Disease As a Cause of Bilateral Renal Calculi*

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Two cases of hyperparathyroidism were found in 20 cases of bilateral urolithiasis. Clinical and chemical studies are described, with critique of the tests and suggestions for improvement.

CALCULUS formation in the urinary tract was a prominent feature of the first explored American case of hyperparathyroidism and of many series of cases subsequently reported.[1, 2, 3, 5, 8, 15, 25, 37] Recently Cope[15] reported that 130 of the first 230 cases of hyperparathyroidism seen at the Massachusetts General Hospital had calcification in the urinary tract.

Conversely, hyperparathyroidism has been reported as the cause of from 0.67 to 10%[4, 15, 37, 38] of cases of calculus disease. The report of Raines and Bradley[37] probably represents the truer incidence since all 1,395 cases of urinary calculus disease admitted to a urology service at a Veterans' Hospital were screened and nine cases of hyperparathyroidism were found. The other series reported may well represent a pre-screened group of referred patients.

Symptoms and Signs

Figure 1, adapted from Reifenstein,[38] shows some of the proposed physiologic bases of symptoms. This shows the main action of the glands as: (1) decreasing the reabsorption of phosphorus by the renal tubules, and (2) the proteolytic action.** The figure shows the pathogenesis of the well-documented osseous, neuromuscular and renal symptoms. Recent papers emphasize the occurrence of duodenal ulcer[15, 28, 39, 40, 42] and of mental disturbances[21, 47] with hyperparathyroidism. Bogdonoff and associates[8] called attention to the occurrence of occlusive vascular disease due to calcification of arterial walls. (See next page.)

Diagnosis

The diagnosis of hyperparathyroidism in a patient suspected because of osseous, neuromuscular, renal, gastrointestinal or mental manifestations depends on the chemical identification of the disease. In decreasing order of reliance, the chemical parameters of the disease are:

(1) Hypercalcemia—levels of calcium in the serum above 11.0 mgm/100 ml.

(2) Hypophosphatemia—levels of blood phosphorus below 3.0 mgm/100 ml.

(3) Hypercalciuria—obligatory excretion of excessive calcium in the urine by patients on a low calcium diet; and,

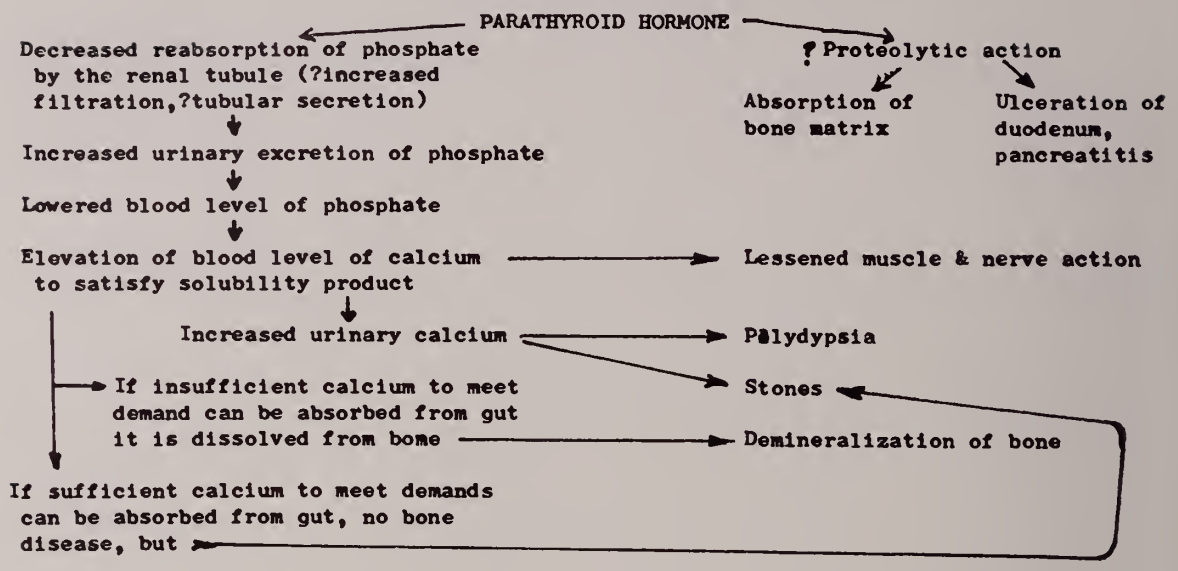
(4) Diminished reabsorption of phosphate by the renal tubule.

Hypercalcemia. Serum calcium determinations either by modifications of the Kramer and Tisdall[11, 12, 20, 32] method or by methods using chelation with EDTA[9, 18, 22, 27, 41] are fraught with lack of reproducibility in small hospital laboratories,[7] whose technicians are not called on for the test often enough to become adept.[17] Keating,[31] whose technician performs the test many times, considers as reliably elevated any level of serum calcium above 10.5 mgm./100 cc. Serum calcium determinations should be judged on the basis of total serum protein concentration. The amount of ionized calcium, which is elevated in hyperparathyroidism, is that portion of the calcium not bound to protein. The bound fraction varies directly with protein concentration, so that a normal calcium

* *Presented at the Kentucky Regional Meeting, American College of Physicians, Lexington, Ky., October 29, 1960.*

** *Since this paper was read Rasmussen and Craig (J. Biol. Chem. 236:759, 1961) have shown that purified bovine parathyroid hormone possesses both calcium-mobilizing and phosphaturic activity.*

Fig. 1. Proposed modes of action of parathyroid hormone



level as determined may actually represent a high level of calcium ion concentration if the total serum protein level is low.[36, 46]

Hypophosphatemia. The level of blood phosphate is subject to diurnal variations; it is often elevated in patients with uremia. Hence it is less reliable, though less difficult to determine accurately, than calcium.

Hypercalciuria is demonstrated by placing the patient on a Bauer-Aub diet[6] containing a daily ration of about 100 to 130 mgm. of calcium for a period of four to six days and measuring the 24-hour output of calcium. Values of 200 mgm. per day are high and suggest hyperparathyroidism.

It is worthy of note that three litres of local water, containing 50 parts per million of calcium, contain 150 mgm. of calcium, or more than is in the Bauer-Aub diet. In these studies patients have been allowed to drink only distilled water and beverages made with distilled water during the testing for hypercalciuria.

Diminished Tubular Reabsorption of Phosphate

In 1954 Schaaf and Kyle[43] showed that whereas normal subjects reabsorbed from 85 to 95% of the phosphate filtered by the glomerulus, three patients with hyperparathyroidism reabsorbed an average of only 58%. Reabsorption by normals was unaffected by changes of serum calcium levels but was reduced by infusion of parathyroid hormone.

The test is easily performed. A timed urine specimen from a fasting subject with adequate intake of water is measured for volume, phosphorus and creatinine. A blood sample is analyzed for phosphorus and creatinine. The concept of the test is likewise straightforward and is in agreement with previously developed concepts of parathyroid action.[4, 16, 26] The tubular reabsorption of phosphate is calculated as follows: The glomerular filtration rate is approximated by the creatinine clearance,[35] measured by urine volume per minute and the concentrations of creatinine in blood and urine. The amount of phosphorus in one minute's glomerular filtrate is the product of the glomerular filtration rate in ml. per minute and the serum phosphate concentration. The amount of phosphate in one minute's urine is the minute volume of urine times its phosphate concentration. The phosphate of the glomerular filtrate not excreted in the urine must have been absorbed by the tubules. A mathematical sophistication even eliminates the necessity of timing the urine collection by using a derived formula.

The TRP test was widely accepted because of its simplicity and because it offered a means of checking the results of calcium determinations. Accumulated experience of various authors[10, 23, 44, 45, 46] reveals a wide overlap in normal and hyperparathyroid subjects and a

non-specificity of the test[19, 45] which is disappointing. Normal humans modify their percentage of TRP in response to changes in phosphate intake.[10, 24]

Chambers, Goldman and their associates[10, 23] consider the normal range of %TRP to be 85 ± 5%. They found that 22 cases of hyperparathyroidism ranged in %TRP between 50% and 82%, and that a low phosphate diet raised the values to a maximum of 85% in hyperparathyroidism, whereas in normal subjects phosphate restriction raised the percentage of reabsorption to 90% or over.

Thomas, Connor, and Morgan[46] found low values for %TRP in 11 out of 14 hyperparathyroid patients and also in seven other patients with hypercalcemia of non-hyperparathyroid origin. These results show the lack of specificity of the test.

Kyle, Schaaf, and Canary[33] proposed the use of the measurement of phosphate clearance to avoid some of the technical errors of the TRP test.

Other Tests of Parathyroid Function

A. Howard's group[29] observed differences between normal and hyperparathyroid response to injection of 15 mgm./kilo of calcium. Kyle, Schaaf, and Erdman[34] thought the test promised great usefulness. Thomas, Connor, and Morgan[46] found the response of 18 patients with hyperparathyroidism and of 10 patients with hypercalcemia from other causes to be quite similar, though different from that in normal subjects. Goldman's group[23] found that six of their 17 cases of hyperparathyroidism gave normal results by this test. It has not been used in these studies.

B. The phosphate deprivation test, devised by Reifenstein,[10] was not used in these studies because the end effect is measured by multiple calcium determinations. It is planned to use phosphate deprivation in future studies for stabilizing values of %TRP before checking them.

C. Connor and others[13] commented favorably on the use of cortisone-induced return to normalcy of hypercalcemia as an exclusion test of hyperparathyroidism. They stated that many, but not all, non-hyperparathyroid cases of hypercalcemia showed correction by steroids and that they observed no cases of hyperparathyroidism in which the hypercalcemia was corrected by cortisone. They recommended this as a test for hyperparathyroidism. The test has not been used in this study.

D. X-ray changes in bones and in the lamina dura of teeth are usually helpful only in the presence of far advanced bone disease.

Results

Between November 1954 and October 1960, 20 patients with bilateral renal or ureteral calculi have been studied with respect to hypercalcemia, hypophosphatemia, hypercalciuria, and per cent tubular reabsorption of phosphate. Since hyperparathyroidism is a generalized disease without good reason to strike only one kidney, it was thought that unilateral calcification would best be investigated locally before subjecting patients to the expense of multiple chemical determinations.

In tabulating the 20 cases, positive results were considered to be serum calcium levels of 11.0 mgm./100 ml. or higher; serum inorganic phosphorus values below 3.0 mgm./100 ml.; 24-hour urinary calcium excretions of 200 mgm. or higher; and percentages of tubular reabsorption of phosphate below 87%.

Table 1 summarizes 10 of the investigated cases. In Cases 1 and 16 the chemical diagnosis was confirmed at operation. Case 1 was found by a urologist to have blood spurting from the right ureter. A KUB film showed bilateral nephrocalcinosis and fuzzy bones. Further x-rays showed generalized bone disease (Figure 3). The radiologist found a KUB film and a chest film (Figure 2) which had been made six years previously when the patient had been seen at the Cancer Clinic. Rib biopsy in 1954 showed no maligant cells and was consistent with osteitis fibrosa cystica. At exploration an 8-gram parathyroid adenoma was removed. Postoperatively she recalcified her deformed bones (Figure 4) and built back her hemoglobin to 13.0 gm./100 ml. She died 16 months postoperatively, presumably of some upper abdominal catastrophe. Autopsy was not obtained.

(See following pages for Table 1, Figures 2-4.)

Case 16 looked like hyperparathyroidism with all parameters positive, including %TRP's of 77 and 75%. After the 0.65 gram parathyroid adenoma had been removed the original laboratory calculations were found to be erroneous in that the second %TRP should have been reported as 87%.

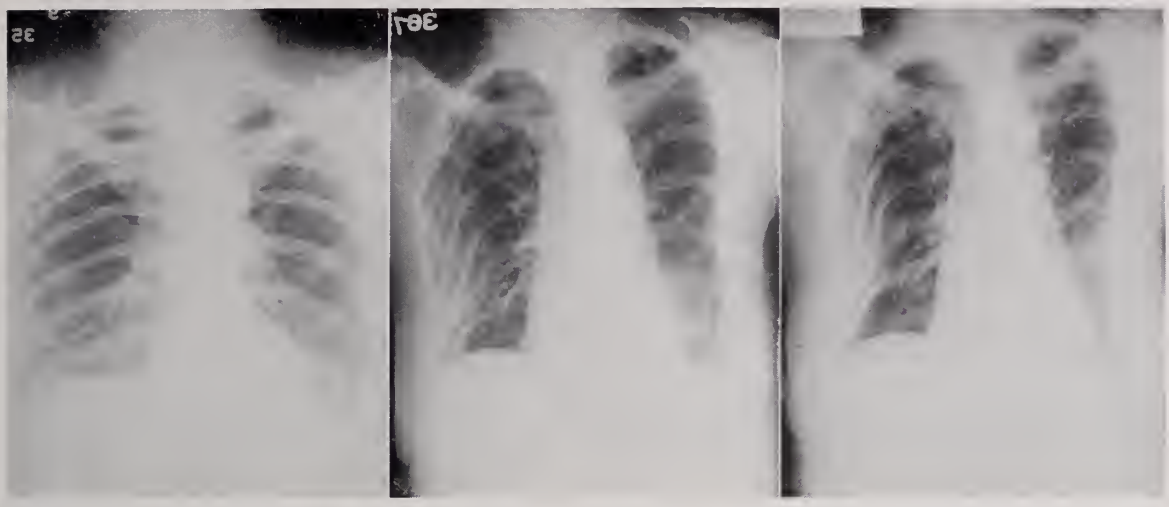
Cases 6, 11 and 12 were still under suspicion when last seen. Case 6 was first seen a few weeks after the first Peter Bent Brigham kidney transplantation had made the news weeklies. Having lost one kidney three months previously, he prefaced his chief complaint with the statement, "By the way, I have an identical twin who has not had kidney stones." His chemical diagnosis was not confirmed at neck exploration. Mediastinal exploration was refused. He moved to Washington shortly after his twin (Case 11) started passing stones and exhibiting signs of hyperparathyroidism. They were told to see Doctor Kyle.

Case 12 seems to need no apology but to have her mediastinum explored. A single 24-hour urine calcium 11 months after negative neck exploration was normal. This was done while she was still draining pus from a ruptured diverticulum of the colon.

TABLE 1.

Clinical and chemical data on 10 of 20 stone formers studied.

CASE	DATE	Ca mg. %	P mg. %	CaU mg./d	Ccr ml./min.	% TRP	COMMENTS
Case #1, 54CF Hematuria 5 mo.	12/54	19.8	2.3	—	14	80	8 gm. Adenoma rt. inf. pthd.
Hgb. 6.7, wt. loss 30 lbs. Anorexia, weakness, pain, bone cysts.	+3 wk.	10.5	2.4				
	+3 mo.	10.7	4.0				Hgb. 13.8. Bones recalcifying.
	+15 mo.						Died, ? D. Ulcer. No Autopsy.
Case #3, 41 WM Wbc & Alb., '53 Bilat. nephrocalcinosis.	6/55	11.2	3.6	256	60	66	Prot. 7.5, A:G 0.9.
	+2 mo.	9.3	2.7		87	78	O followup.
Case #6, 32 WM Bilat. stones, 2 yrs. Rt. nephrectomy. Has ident. twin. Case 11.	1/56	12.8	1.9	510	88	83	
	+1 wk.						Neg. neck expl. O followup re mediastinal exploration.
Case #7, 56 WM Bilat. stones 27 yrs.	3/56	12.5	3.6	170	59	86	Prot. 6.4, A:G 1.0 Has duod. ulcer.
	+2 yrs.						
Case #8, 53 WM Stones 23 yrs. Rt. ureterolithot., 1954. Ulcer '42 Osteoma lt. femur,	-1 yr.	9.9	4.4				
	4/56	14.5	2.4	196	108	86	
	+3 mo.	11.0	2.2	156	117	88	Tender mass rt. neck
	+13 mo.	12.0	3.0				In for stone extn; nodule in neck.
	+21 mo.	12.5	4.6				Thyroidectomy; parathyroids neg.
	+38 mo.						No stones since.
Case #9, 37 WM 80 stones past 3 yrs.	4/56	11.0	3.6	"Normal"	98	93	Prot. 8.0, A:G 1.0 Neg. neck expl.
	+23 mo.						Fewer stones on low Ca diet.
Case #11, 33 WM Twin of #6. Rt. uret. calc. 1 mo.	1/57	11.3	3.0	230	89	85	O followup. Moved.
Case #12, 44 WF Stones 22 yrs. 20 hosp. adms. Bilat. pelvio- & ureterolithots. Mandibular cyst. Teeth ext'd.	—8 yr.	11.6	3.2				
	—4 yr.	14.4	3.6				
	—1 yr.	13.2	2.7				
	3/57	11.7	2.7	279	33	67	
	+30 mo.	10.1	2.4				
	+32 mo.	11.0	2.7	283	77	79	Neg. neck expl.
	+43 mo.			140			O stones since.
Case #16, 49 WF Stones 12 yrs. 3 ureterolithotomies	—3 mo.	12.2	3.1	353	94	77	
	2/59	12.5	2.6		120	87*	0.65 gm. adenoma, rt. inf. pthd.
					*Miscalculated as 75		
	+3 mo.	10.1					Lt. renal calcification less dense.
Case #17, 44 WM Stones 25 yrs. partial nephrect. 2 ureterolithots.	—51 mo.	11.0	2.8				
	5/59	10.1	1.5	177	14	0	? Tubular secretion.
	+13 mo.	12.1	2.6		24	39	



Left to right: Figure 2 — Chest film, Case 1, September 7, 1948, six years before onset of disease. Figure 3 — Chest Film, Case 1, November 29, 1954, preoperatively. Figure 4—Chest film, Case 1, March 4, 1955 three months postoperatively.

In two cases negative explorations were predicted. While Case 8 was being investigated, with fair evidence of hyperparathyroidism, he became aware of Case 9 on a different service, across the hall from him. When Case 9 had a negative exploration Case 8 refused surgery despite protestations of Case 9's negative chemistries. He was right. He was studied later in 1956 after he had passed another stone and had developed a sore mass in his neck. The parameters of hyperparathyroidism had returned toward normal. It was thought that this might represent an infarction of an adenoma.[28] Two stones later his nodular thyroid was resected. No sign of parathyroid disease was seen.

Cases 3, 7, and 17 are also deserving of comment. Surgery was deferred in Case 3 becausc of reversal of A:G ratio and some peculiar pulmonary calcification. Later investigation raised doubts of the validity of his hypercalciuria.

Case 7 had unimpressive chemical data—no hypophosphatemia, no hypercalciuria and an unreliable %TRP. A recent follow-up by his urologist indicates that he had developed a duodenal ulcer. Perhaps he should be reinvestigated.[15, 28, 39, 40, 42]

Case 17 merits further study of the reason why he excreted more phosphorus in his urine than got there in the glomerular filtrate. He apparently exhibits the phenomenon of tubular secretion of phosphate.[14, 30]

The other 10 patients had chemical findings not suggesting hyperparathyroidism. Six patients never exhibited hypercalcemia. Four had hypercalcemia. One, who was hypophosphatemic, showed no hypercalciuria and had a high %TRP. Another had hypercalciuria only slightly above 200 mgm.; his TRP was 97%. He was in the Air Force at the time this paper was written. The hypercalciuria of the third hypercalcemic was equivocal on the first determination, and five years later only the %TRP was suggestive. In the other there was no hypercalciuria and the figure for %TRP was considered to be unreliable at the low level of creatinine clearance.

Discussion

This study showed little value of the TRP test in clinching the diagnosis of hyperparathyroidism in two positive cases. In Case 1 the creatinine clearance was too low to be reliable. A positive test in Case 16 was recalculated after her adenoma had been removed and found to be negative.

However, the test was of value in rejecting thc diagnosis of hyperparathyroidism in four cases. Low rates of TRP were found in five cases whose other parameters did not suggest hyperparathyroidism.

It would be a tremendous job to calculate exactly the amount of time and money expended by the 20 patients for several five-day hospitalizations with multiple chemical analyses; for internists, surgeons, pathologists, anesthesiologists; and for urologists to extract stones while awaiting decisions by patients and internists. At first glance it would appear to exceed the amount which would have been expended for routine surgical explorations of all

20, which would still have yielded at least two adenomas. This approach is not recommended, however.

This thought leads to planning a procedure for the next 20 chemical explorations. The problem might be attacked more systematically by: (1) Correlating the laboratories of local hospitals with a view to standardizing methods and gaining experience for a single technician and, (2) instituting a pre-screening standardization of dietary intake designed either to exaggerate the abnormalities delineating suspect and non-suspect or to increase the reliability of data yielded and to shorten hospitalization.

The proposed procedure consists of six days of low-calcium, low-phosphorus diet at home; hospitalization for a 24-hour urine collection for calcium, creatinine and phosphorus, with a blood sample to be analyzed for calcium, phosphorus, alkaline phosphatase, total protein, albumin, and creatinine. This procedure should not affect the reliability of serum calcium and phosphorus levels, but should increase the reliability of the calcium excretion figure, and should eliminate a good number of false positive tests for %TRP.

The pre-screening diet should consist of unenriched Vienna bread, oleomargarine and bananas, which could be carried in a lunch box with a thermos bottle of distilled water; egg whites, pineapple juice, prunes, rice, tomato juice, apple sauce, gelatin, jello, cranberry jelly, blueberries, apple juice, coffee, tea, sugar, salt, pepper, and distilled water to be ingested at home. This is the low-phosphorus diet devised by Chambers et al.[10], modified by the deletion of calcium gluconate. Its calcium content should be 700 mgm. minus the 530 mgm. of calcium in six grams of calcium gluconate, or 170 mgm. This procedure should cut expenses considerably by yielding more dependable results and by shortening hospitalization for testing.

Summary

1. Probable modes of action of the parathyroid hormone have been described. Methods of detection of hyperparathyroidism have been discussed.

2. Studies of blood calcium, blood phosphorus, calcium excretion, and tubular reabsorption of phosphate have been performed on 20 cases of bilateral renal calculi. The diagnosis of hyperparathyroidism has been confirmed in two cases by surgical extirpation of parathyroid adenomas.

3. Chemical diagnosis of hyperparathyroidism was made and not confirmed by neck exploration in two cases whose mediastinums have not yet been searched. The supposed identical twin of one of these cases also has chemical evidence of hyperparathyroidism and has not been explored.

4. Neck explorations of two cases with little evidence of hyperparathyroidism have been unyielding.

5. The diagnosis of hyperparathyroidism is still suspected in three other cases. One of these appears to demonstrate the phenomenon of tubular phosphate secretion.

6. Hyperparathyroidism was thought to have been reasonably rejected in the remaining 10 cases.

7. In balance studies on low calcium diets it should be borne in mind that the ingestion of three litres of local hard water may afford more calcium than the 100 to 130 mgm. in the Bauer-Aub diet. Therefore, while under study, these patients should drink only distilled water.

8. It was hoped that measurement of the tubular reabsorption of phosphate would be a valuable aid in the diagnosis. It may be of value in rejecting the diagnosis but its value in establishing the diagnosis was not demonstrated.

9. These 20 patients had been passing stones for an average of 12½ years before these studies were performed. They were therefore urologically suspected of hyperparathyroidism and represent a selected group of renal calculi. No inference should be drawn as to the incidence of hyperparathyroidism in warm limestone country, sweating, male stoneformers. It might be worthy of note that two of the four women studied yielded adenomas and that a third woman is still suspected.

10. Means of improving the accuracy and cutting the cost of the chemical exploration are proposed.

(References will be available on reprints of this article.)

Kentucky Thoracic Society Committee Report on the Treatment of Tuberculosis

Educational Committee of the
Kentucky Thoracic Society*

This report gives concisely essentials of medical and surgical management of commonly encountered tuberculosis problems—diagnosis, indications for treatment, drugs and dosages, management of tuberculin converters, drug resistance, surgical treatment when required.

ESTABLISHING a specific and definite diagnosis is, of course, a preliminary step in the treatment of tuberculosis.

The value of tuberculin testing has long been recognized and induration of 5 mm. or more indicates a positive test. In recent years it has been observed that induration measuring 10 mm. or more carries a higher risk for developing active tuberculosis. A radiograph of the chest in suspected tuberculosis cases should certainly be a routine procedure and the importance of reviewing previous films and serial radiographic observations cannot be over-emphasized. It should also be stressed that sputum and/or gastric bacteriologic studies must be done before treatment and periodically during the course of management of tuberculosis.

With the very first positive sputum or gastric specimen, drug susceptibilities on the isolated tubercle organisms should be determined in order that the appropriate chemotherapeutic regimen can be administered. Even when patients deny sputum production, every attempt should be made to obtain a sputum specimen, even though scanty, for smear and culture. Obviously, these initial diagnostic procedures can be readily accomplished in an office practice, clinic or the hospital.

Once a diagnosis of active tuberculosis is made and the tubercle organisms are isolated, hospitalization, at least during the infectious or contagious stage of the disease, is recommended. The major anti-tuberculosis agents, isoniazid, PAS and streptomycin, are still the essential drugs in the treatment of tuberculosis.

Indications and Dosage

The indications for therapy are as follows: All sputum positive patients should be hospitalized and treated intensively until sputum conversion has been established. Isoniazid and PAS should be administered in all cases and in severe and complicated cases streptomycin daily is usually added. On discharge from the hospital, the treatment usually consists of isoniazid and PAS for one year or possibly two or more years after hospitalization.

Children under the age of three years and tuberculin positive should be treated with isoniazid alone for at least a year. Children more than three years of age who have converted within a year from negative to positive tuberculin should receive a full year of isoniazid therapy. Children with primary pulmonary tuberculosis, lymphadenitis or other forms of extrapulmonary tuberculosis should receive isoniazid and PAS.

In tuberculous meningitis and miliary tuberculosis, triple drug therapy is usually administered during the early months of treatment and may be modified later. Steroid therapy is indicated in cases of meningitis and in severely toxic tuberculous patients. The other antituberculous drugs, such as pyrazinamide, cycloserine, viomycin and kanamycin, should be considered only under special circumstances in a hospitalized patient excreting resistant tubercle bacilli.

The usual dosage of isoniazid in children is 15 mg. per kg. daily, taken in two or three

*Members of the Committee at the time of the report's preparation: R. E. Mardis, M.D., Louisville, chairman; Walker Porter Mayo, M.D., and Kurt W. Deuschle, M.D., both of Lexington; and Norman B. Hasler, M.D., and Herbert T. Ransdell, Jr., M.D., both of Louisville.

doses. PAS (para-aminosalicylic acid) is the most commonly used companion drug to isoniazid and is given in a dosage of 200 mg. per kg. per 24 hours. Streptomycin when used in the more serious or complicated tuberculosis problems in children is administered intramuscularly in a dose of 20 mg. per kg. per day. Dihydrostreptomycin is contraindicated in pediatric practice because of irreversible auditory nerve toxicity. When corticosteroids are employed in the infant or child with pleurisy, meningitis and various dangerous tuberculous conditions, the dose of prednisone, for example, is 1 mg. per kg. per day for two to three months, with gradual withdrawal.

Tuberculin Conversion

Adult patients whose only evidence of tuberculosis is a recent tuberculin conversion should be treated with isoniazid alone for a period of a year. Minimal tuberculosis may be treated with isoniazid alone but moderately and far advanced tuberculosis and the various forms of extrapulmonary tuberculosis should be treated with a combination of isoniazid and PAS.

In adults the dose of isoniazid should be 5-8 mg./kilo. body weight and PAS 10-12 gms. daily in divided doses. Chemotherapy in all instances should be intensive, uninterrupted and prolonged for at least one year after the tuberculosis has become inactive as determined by x-ray, bacteriologic and clinical criteria.

In patients who have a poor nutritional intake, as in the case of alcoholics, one must be on guard for the toxic manifestations of isoniazid. PAS toxicity can be severe although the most frequent complaints are mild gastro-intestinal symptoms.

Patients who are on steroid therapy for a variety of non-tuberculosis disease problems, but have a positive tuberculin test, should be treated with isoniazid alone as a prophylactic measure.

It is not practicable to go into details regarding special management problems of tuberculosis in a report of this type. If the patient has a complicated tuberculosis problem, the practicing physician with limited experience in tuberculosis management would be well advised to obtain expert help.

Chest consultants or physicians at the State Tuberculosis Hospital have the special experience necessary to evaluate and manage these complicated tuberculosis cases.

Drug Resistance

Unless the chemotherapeutic agents are handled properly, it is possible to do more harm than good. Poorly administered chemotherapeutic programs may result in an increasing prevalence of drug-resistant organisms. Hospitalization for infectious tuberculosis patients has already been emphasized but early discharge from the hospital can be anticipated. Prolonged medical surveillance, in fact, lifelong observation of these patients following hospitalization, is required. For the physician in practice, it is important to realize that the tuberculosis problem has not vanished and he must look forward to facing this disease problem for many years to come. The physician must remain alert to the possibility of tuberculosis in his patients; he must follow the essential triad of diagnostic procedures (tuberculin testing, chest x-rays, sputum examinations); and he should consult with specialists in chest disease for management of the problem when appropriate.

Medical management alone is sometimes not sufficient to effect control or arrest of tuberculosis. There are definite considerations and indications for the addition of surgical treatment of tuberculosis described in the section that follows.

Surgical Treatment

The surgical care of a patient with pulmonary tuberculosis must be an integral part of a therapeutic regimen complementing the medical treatment. The entire medical and surgical program should be tailored to fit the individual patient. Surgical treatment in pulmonary tuberculosis usually is not undertaken until the patient has had six months of antimicrobial therapy. This period of time allows the elimination of toxemia, reduction of excessive bronchial secretions and the control of active lesions in other lung areas. Also, the reversible component of the infectious process may be greatly improved, permitting more limited resection and less danger of postoperative tuberculous complications.

Disease which will not heal satisfactorily with bed rest and long term antimicrobial

therapy, or which will not remain healed on such a regimen, constitutes the primary indication for surgical treatment of pulmonary tuberculosis. Resection of diseased tuberculous tissue is the surgical treatment of choice in the majority of patients. The ideal case for resection is the patient with unilateral localized disease under treatment with primary uninterrupted drug therapy. Pulmonary resection has as its objectives the excision of the diseased areas of lung and maximum preservation of pulmonary function. It may be possible to remove most but not necessarily all of the tuberculous involvement of the lung; therefore, it is essential that chemotherapy be continued for not less than six months after surgery and preferably for a year or longer.

Pulmonary Resection

In the treatment of tuberculosis prior to the introduction of anti-tuberculous drugs, pulmonary resection met with excessively high morbidity and mortality rates; therefore, its use was limited. Refinements in the techniques of anesthesia and surgery as well as adequate blood replacement and increased knowledge of pulmonary function have materially improved the success of resection therapy.

The most important advance, however, has been the introduction of antimicrobial drugs. The better preparation and the protection offered patients by the antimicrobial therapy have not only enchanced the effectiveness of resection and other surgical measures but also have increased the number of patients eligible for surgical procedures. Pulmonary resection is unquestionably the most important surgical procedure employed in the treatment of pulmonary tuberculosis. Due to the excellence of the over-all results, the widespread acceptance of resection is justified.

Indications For Resection

The indications for pulmonary resection in tuberculosis are reasonably clear cut and consist of the following.

1. Open cavity with or without positive sputum after three to six months of treatment on a combined drug regimen.
2. Residual caseous nodules, remaining after adequate treatment, of such a size that they might not be expected to heal well. Included in this group are blocked cavities and tuberculomas.
3. Unanticipated slow resolution of disease under presumed adequate antimicrobial therapy.
4. Diffuse nodular disease of not too great extent.
5. Chronic fibroid disease with positive sputum.
6. Atelectasis of a segment or lobe.
7. Bronchial stenosis in which bronchial repair is not possible or in which distal disease makes bronchial repair unwise.
8. Bronchiectasis with positive sputum or with symptoms.
9. Destroyed pulmonary segment, lobe or lung.
10. Failed thoracoplasty.
11. Suspected neoplasm.

The possibility of coexisting pulmonary tuberculosis and carcinoma must be recognized, especially in middle-aged male patients. If carcinoma is a distinct possibility, it is the primary consideration regardless of the status of the tuberculosis.

Resection Type Therapy

Resection type therapy is the procedure of choice in practically every instance of tuberculosis requiring surgical therapy as an adjunct to medical care. Resection of segments, lobes or an entire lung may be indicated. Pulmonary resection is preferred to collapse therapy because it offers more definite and permanent means of control; it is generally more conserving of respiratory function and avoids the late complications of artifical pneumothorax and extra pleural plombage. Other favorable factors are the shorter periods of morbidity, earlier rehabilitation, and a more rapid hospital turnover of patients.

The temporary forms of collapse therapy such as pneumothorax and pneumoperitoneum have extremely limited indications. Definite indications for permanent forms of collapse such as thoracoplasty and extrapleural collapse procedures continue. When serial roentgenograms demonstrate instability and lack of proper healing despite adequate treatment, the decision for resection is strengthened. Reactivation of disease in a patient previously treated by sanatorium care makes resection advisable.

There are unstable patients who cannot be expected to lead a restricted life following discharge. Resection may provide additional pro-

tection for such patients and the public, although resection is not a substitute for adequate medical care. If a patient must work hard for a living, it is hoped that resection will offer a greater chance of cure than a medical regimen alone.

Finally, there is a tendency to recommend resection for young patients with a probable long life span. Pulmonary resection in the treatment of childhood and teenage tuberculosis is well tolerated.

Pulmonary resection has become the most important surgical procedure employed in the treatment of pulmonary tuberculosis. The decision to carry out pulmonary resection or other surgical measure should be a joint effort by the internist, thoracic surgeon, radiologist and bacteriologist.



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Hyperthyroidism: Clinical Aspects*

Henry Evans, M.D.

Harlan, Ky.

Various manifestations of hyperthyroidism and some methods of treatment are discussed. Data on 61 patients treated for hyperthyroidism are presented.

DURING the 19th century, hyperthyroidism was widely discussed among European clinicians. Priority in description is usually given to Caleb Parry, an English physician, who described eight cases of hyperthyroidism, the first of which he attended in 1786.[1] He called attention to the goiter, the prominent eyes and "enlargement or palpitation of the heart."

The best known description of hyperthyroidism is that of Robert Graves, the famous Irish clinician and teacher, who in 1835 wrote on a "Newly Observed Affection of the Thyroid Gland in Females."[2] In Germany, Carl von Basedow also pointed out the clinical triad of struma, exophthalmos and palpitation of the heart. J. M. Charcot made exophthalmic goiter well known in his famous Tuesday morning lectures and Pierre Marie, Charcot's pupil, wrote his doctoral thesis on "Basedow's disease." It was not until 1928 that S. H. Plummer clearly differentiated Graves' disease from nodular goiter with hyperthyroidism (Plummer's disease).

Symptoms and Signs

Hyperthyroidism is a disorder of the thyroid gland in which the clinical manifestations are attributed to an increased secretion of thyroid hormone. Thyrotoxicosis emphasizes the disturbances resulting from excessive action of the thyroid hormone on the peripheral tissues. Graves' disease is the clinical triad of goiter, exophthalmos and thyrotoxicosis. All of these terms have been criticized, largely because they overemphasize one aspect of the disease or they suggest etiological factors while the precise etiology remains unknown.

The concept of a "Graves' disease state"[3] appears to aid in clarification of what is seen clinically. This concept encompasses the ocular abnormalities and changes in thyroid function which usually occur together but may appear as isolated manifestations in a given patient.

Goiters associated with hyperthyroidism may be divided into diffuse (Graves' disease) and nodular (Plummer's disease). The latter may be subdivided into those with a single nodule, which are uncommon, and those with multiple nodules, which are common. It is generally agreed that hyperthyroidism with a small diffuse goiter differs, in some of its manifestations and in its response to treatment, from hyperthyroidism seen with a large nodular goiter. Thus, classification and estimation of the size of the goiter is important in planning the management and in estimating the prognosis in each patient.

Hyperthyroidism

Hyperthyroidism may occur at any age, but it is most common in the third and fourth decades. Those patients with a nodular goiter are usually in the older age group. Females are more commonly affected than males. The onset of the disease is usually slow, several months elapsing before medical attention is sought. Sometimes there is a history of emotional upset near the time of onset of the illness. The presenting complaints illustrate the widespread action of the thyroid hormone on practically every body system. Complaints of nervousness, tremor and palpitations are common. Usually there is weight loss with a good appetite. Fatigue and weakness are prominent. There may be polydipsia, polyuria, diarrhea and in-

* *Presented at the Postgraduate Course on Endocrine Disorders, University of Kentucky Medical Center, Lexington, Ky., January 25, 1962.*

tolerance for heat. On occasion the presenting complaints may be burning or protrusion of the eyes, lacrimation or double vision. The patient may have noted development of a goiter.

The small, firm, diffuse goiter and exophthalmos are the classical signs in Graves' disease. A characteristic stare, lid lag and other eye signs are present. The patient is restless and irritable, has a warm, silky skin and a fine tremor of the hand and tongue. The pulse is rapid and the pulse pressure wide. There is commonly a bruit over the gland and a systolic apical murmur. Atrial fibrillation may be present. Lymph nodes and occasionally the spleen are palpable. The deep tendon reflexes are characteristically quickened. Patients with a nodular goiter have few or no eye signs, exophthalmos is not present and cardiovascular disorders tend to predominate.

Laboratory tests and diagnosis will not be considered in this paper.

Treatment

It is clear that there is not universal agreement on the best treatment for hyperthyroidism.[4] The manifestations of the disease and available modalities of therapy are so varied that each patient must be carefully selected and treatment individualized.

In selected cases antithyroid drugs may be used as definitive therapy, hopefully to obtain a prolonged or permanent remission. Such remission is obtained in 60 to 70% of cases. An antithyroid drug may be used to control severe symptoms prior to the use of radioactive iodine and in such a case the drug may be restarted a few days after the dose of radioactive iodine. Sometimes a therapeutic trial of antithyroid drug is useful in diagnosis. Methimazole (Tapazole®) is commonly used in a dosage of 15 to 40 mgm. per day in evenly divided doses with a maintenance dose of 5 to 15 mgm. per day. Propylthiouracil may be used similarly in doses of 300 to 400 mgm. per day with a maintenance dose of 50 to 300 mgm. per day.

In general, a subtotal thyroidectomy is indicated in those patients with a large nodular goiter, with obstructive symptoms, with a single nodule or in those too young for radioactive iodine. (The lower age limit for radioactive iodine is arbitrary and has been set at 40 years for the patients we have treated.) In preparation for the operation the patient is treated with an antithyroid drug until he is euthyroid. Care must be taken to avoid hypothyroidism. Lugol's solution five drops two or three times a day is prescribed during the week prior to the operation.

Radioactive iodine is indicated in recurrent hyperthyroidism after subtotal thyroidectomy or after antithyroid drug treatment in those patients not considered to be too young. In psychotic patients or in those with serious intercurrent disease radioactive iodine may be the drug of choice. The best results are obtained in patients with Graves' disease, over 40 years of age, with a small gland. The dosage of radioactive iodine is in the range of 100 to 150 mc. per estimated gram of thyroid tissue depending upon the judgment and experience of the attending physician.

Summary of Treated Cases

From 1956 through 1961, 61 patients were treated for hyperthyroidism at Harlan Memorial Hospital. Table 1 summarizes the types of treatment. Two patients were considered to have "Graves' disease state" and were not treated in the usual manner for hyperthyroidism. One of these had a small goiter, fairly severe exophthalmos and a normal metabolic rate and was treated with desiccated thyroid. One patient with definite exophthalmos, but no other manifestations of Graves' disease, is being followed.

Table 1

Patients by Type of Treatment

Radioactive iodine		33
Graves' disease	12	
Toxic multinodular goiter	21	
Surgery		16
Antithyroid drugs		10
Other		2
Total		61

Table 2 summarizes the surgically treated

Table 2

Patients Treated Surgically

Graves' disease	8
Toxic multinodular goiter	6
Fetal adenoma	2
Total	16
Complications	
Recurrence of hyperthyroidism	1
Laryngeal nerve damage (improved)	1

patients. There was no surgical mortality in this small group. The surgical complications are also listed.

A summary of the patients treated with radioactive iodine is given in Table 3. It is noted that in this small group males with

Table 3

Patients Treated with Radioactive Iodine

Graves' disease	12
Age range 42 to 67, average 51	
Males 6, females 6	
Dose range 4 to 14, average 7.2 mc.	
Multiple doses 3	
Complications	
Hypothyroidism	1
Ophthalmopathy	1
Toxic multinodular goiter	21
Age range 46 to 73, average 63	
Males 3, females 18	
Dose range 2 to 11, average 8.0 mc.	
Multiple doses 2	
Complications	
Hypothyroidism	0
Died, other cause	1
Hyperthyroidism uncontrolled	2
Longer follow-up inadequate	5

Graves' disease were as common as females, and females with multinodular goiter and hyperthyroidism made up nearly one-third of the total of treated patients. This is not the general experience and may be due in part to the frequency of nontoxic nodular goiter seen in older women in this area or to the types of patients referred to this hospital for diagnosis and treatment.

Patients treated with radioactive iodine are seen for follow-up at approximately monthly intervals. Retreatment is not given until eight or ten weeks have elapsed and then only if there is good clinical, and usually laboratory, evidence of persistent hyperthyroidism. As the patient becomes euthyroid re-evaluation is made at increasingly longer intervals.

Illustrative Cases

Case 1—A child with Graves' disease treated with an antithyroid drug.

A seven-year-old girl was admitted to the hospital on July 19, 1960 because of protrusion of the eyes and swelling of the neck for six months. She had become nervous and jittery and lost some weight, but had gained five inches in height during the preceeding six months.

Her only past illnesses were the usual childhood diseases and bronchopneumonia on three occasions.

The mother, grandmother and maternal aunt also had goiters.

The girl was 54 inches tall and weighed 59 pounds. The pulse was 120 per minute. There was a marked exophthalmos, lid lag and poor convergence. The thyroid gland was diffusely enlarged with a loud bruit easily heard.

The B.M.R. was +11%, cholesterol 200 mgm. %, P.B.I. 15 mcg. % and I^{131} uptake 87% at 24 hours.

After four weeks treatment with propylthiouracil, 100 mgm. every six hours, she had gained six pounds and appeared much improved. The P.B.I. was then 11 mcg. %.

Gradually the propylthiouracil was reduced to 50 mgm. twice daily. The goiter has decreased in size and the child is growing well. After 18 months treatment, her P.B.I. is 7.8 mcg. %. Hopefully her antithyroid drug can soon be withdrawn without recurrence of her symptoms.

Case 2—Graves' disease treated with radioactive iodine.

A patient with fairly typical Graves' disease, a white woman 42 years old, was seen on June 1, 1961 complaining of shaking of the hands and weakness for six or seven months. She had lost about four pounds of weight. Her appetite was normal. She tolerated cold weather better than in the past and complained of weakness, particularly in the legs. She thought her neck had been full for about four years. She had no eye symptoms.

She had psoriasis and x-ray evidence of an old duodenal ulcer.

A sister had been treated for hyperthyroidism.

On examination her weight was 92 pounds, pulse 110, B.P. 126/76. She had a fine tremor of the hands and appeared agitated and nervous. A stare and chemosis were present but there was no lid lag. The thyroid was estimated to weigh about 30 grams and was smooth and diffusely enlarged. The skin was moist. Deep tendon reflexes were brisk.

The B.M.R. was +42%, the cholesterol 250 mgm. %, the P.B.I. 8.3 mcg. %, I^{131} uptake 48% in 24 hours.

On June 15, 1961 she was treated with 4

mc. of radioactive iodine. Three months after treatment she appeared generally improved and had gained eight pounds in weight. The thyroid had decreased in size. The I^{131} uptake was 31% in 24 hours.

Five months later she was well with no symptoms.

Case 3—Toxic nodular goiter treated surgically.

A 55-year-old woman was referred on May 25, 1961 because of increasing nervousness and choking of about three years duration. She had had a goiter for about 20 years. Her appetite had been variable but she had not lost weight. She complained of irregular heart action and had been digitalized.

Her health in the past had otherwise been good.

The patient's mother, a sister, grandmother and one uncle all had non-toxic goiters.

On examination she weighed 111 pounds. Her pulse was 76 per minute and grossly irregular. There were no eye signs. The thyroid was nodular and estimated to weigh about 120 grams. The ankles showed pitting edema.

The B.M.R. was +39% and +60% on two occasions. The cholesterol was 233 mgm. %, P.B.I. 16 mcg. %, I^{131} uptake 49% at 24 hours. X-rays of the neck showed the goiter to extend below the sternum and to displace the trachea posteriorly.

Treatment was started with propylthiouracil, 500 mgm. a day in divided doses. Digitalis and diuretics were continued. After about three months her nervousness was better, she had lost her edema and plans were made to operate. For two weeks prior to the operation she received Lugol's solution, 10 drops three times a day. A subtotal thyroidectomy was done and 200 grams of tissue removed. The pathological diagnosis was nodular, adenomatous goiter.

Postoperatively she gained in strength and energy and after four months had gained 20 pounds of weight with no signs of congestive failure. She has been continued on a maintenance dose of digitalis.

Case 4—"Graves' disease state" treated with dessicated thyroid.

A 40-year-old woman was referred on December 20, 1961 complaining of swelling and prominence of her eyes for seven months. She had more recently developed double vision. For about a year she had been nervous and aware of rapid heart action but there was no increased perspiration, intolerance for heat, diarrhea or any other symptom of hypermetabolism.

She had been well in the past and there was no family history of thyroid disease.

Her weight was 123, pulse 112 per minute, B.P. 140/85. She was tall, thin and restless and had a marked stare and lid lag. A firm, diffuse goiter, estimated to weigh 40 grams, was palpable.

The B.M.R. was −7%, cholesterol 178 mgm. %, P.B.I. 5.8 mcg. % and the I^{131} uptake 38% at 24 hours. The patient was given thyroid, 180 mgm. a day for three weeks, in an effort to suppress the uptake of I^{131}. The repeat value of 36% showed the uptake to be non-suppressable—a characteristic of the thyroid gland in Graves' disease.

This patient is considered to have a "Graves' disease state." She has a goiter and ocular manifestations at present, but no hypermetabolism. Because of the eye symptoms she has been started on thyroid, 120 mgm. a day. It is too early to evaluate her therapy, but it is hoped the double vision and other complaints with her eyes will improve.

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For A Complete Report on the 1962 Annual Meeting of the Kentucky State Medical Association, Turn to Page 1064

Louisville General Hospital

Hypertensive Cardiovascular Disease with Early Superimposed Toxemia

History

PATIENT Protocol #179048—T. S., a 35-year-old Negro gravida 4, para 3, was first seen in the emergency room of Louisville General Hospital at 9:30 a.m. on July 28, 1962. On arrival at the hospital, the patient was disoriented and exhibited two grand mal seizures while still in the emergency room area.

The patient's mother, who accompanied her, said the patient had been well on the day before admission, but had complained of headaches and swollen feet and ankles for the past three months. On the morning of admission, she had been dizzy and had staggered on arising, whereupon she returned to bed. Shortly thereafter, she had a convulsion and fell out of bed, whereupon her mother became alarmed and brought her to the hospital. No menstrual history could be obtained.

The past history was characterized by several admissions for normal obstetric delivery and occasional outpatient and emergency room visits for minor ailments such as sore throats, colds and superficial abrasion and stab wounds. The patient had not had a convulsion since the age of three years. The last recorded blood pressure was 120/80 in February 1957.

The patient was admitted to the medical service from the emergency room after the intravenous administration of 500 milligrams of sodium amytal.

Physical Findings

On admission, the blood pressure was 250/150; pulse, 110; respirations, 32. The patient was an obese, semicomatose Negro woman of about the stated age of 35 years. There was a large recent hematoma of the left frontal region. The pupils were small and equal. The lungs and heart were normal to percussion and auscultation. The uterus was enlarged to the level of the umbilicus. There was 2+ pitting edema of the extremities. The tendon relexes were equal, and there was a questionable Babinski sign on the left.

Laboratory Findings

On admission, the hemoglobin was 15.6 grams; WBC, 16,980 with 94 polymorphonuclear leukocytes, 3 lymphocytes and 3 monocytes. The uric acid was 13.1 milligrams per cent. Blood urea nitrogen was 15.5 milligrams per cent. Urinalysis showed 4+ albuminuria.

Treatment and Course in Hospital

Shortly after admission, the working diagnosis of eclampsia was entertained, and the patient was admitted to the obstetric service at 12 noon on July 28, 1962. Initially, she was given 15 milligrams of morphine intramuscularly and 10 cc. of 50% of magnesium sulphate. Because of the marked elevation of the blood pressure, apresoline, 100 milligrams in 1,000 cc. of 5% dextrose in water, was started intravenously.

During the five hours which followed transfer, the blood pressure fluctuated between 210/160 and 140/90, eventually becoming stabilized at the latter reading when the apresoline drip was discontinued. The morphine and magnesium sulphate regimen was continued at intervals, and the patient's condition remained relatively stable. At times she responded to stimuli but showed intermittent periods of disorientation. On the day after admission, sodium was 136 milliequivalents. Urea nitrogen was 28, rising to 42 by July 30. Skull films on admission were normal and a chest film was normal except for minimal hypertensive cardiomegaly. Spinal tap on admission showed normal findings only.

On July 31, at 7:05 p.m., the patient was delivered spontaneously of a 13-ounce nonliv-

ing fetus. A complete, apparently normal placenta was passed spontaneously. Following delivery, the patient's mental clarity was improved, and she would respond to commands and began answering questions. At this time the blood pressure was 180/110.

During the morning of August 1, 1962, the patient was fairly alert, and the blood pressure declined slowly from 180/110 to 110/70. At this time, auscultation of the chest showed diffuse rales bilaterally. Suddenly the patient became unresponsive, and showed a gasping type of respiration, several minutes following which the pulse became impalpable, respiratory movements ceased and cardiac sounds could no longer be heard. Attempts at resuscitation proved futile.

An autopsy was performed. There was extensive bronchopneumonia of the entire right lung and of the left upper lobe. Moderately severe pulmonary edema was noted bilaterally, together with severe tracheobronchitis. The heart showed left ventricular hypertrophy of the hypertensive type. There was moderately severe purulent and hemorrhagic cystitis. The brain, adrenal glands, kidneys and liver appeared normal. Microscopic examination did not alter the gross impression. The final diagnosis was that of hypertensive cardiovascular disease with fulminant superimposed eclampsia with minimal anatomical findings.

Discussion

Douglas M. Haynes, M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Louisville School of Medicine.

This case illustrates the syndrome of eclampsia superimposed on hypertensive disease with certain unusual surrounding circumstances. The patient had no prior history of hypertension, and there was evidence that she had no hypertensive disease five years before admission. However, the roentgen and autopsy findings of cardiac hypertrophy of the left ventricular type is convincing evidence of underlying hypertensive disease.

The initial systolic blood pressure of over 200 millimeters of mercury is also far more likely to be associated with an underlying hypertensive disease in a patient with toxemia than to be due to toxemia alone.

It is regrettable that the patient's eye grounds were not examined before the administration of morphine made the examination impractical. The segmental spasm of the retinal arterioles which characterizes pure preeclampsia is strikingly different from hypertensive retinopathy, and helps to make the differential diagnosis. In this instance, it is possible that the early signs of hypertensive retinopathy might have been present.

Physical Findings

The physical findings indicate that this patient was about 24 weeks pregnant, just entering the third trimester. Specific toxemia of pregnancy rarely supervenes until the third trimester with a few notable exceptions. The early onset of toxemia in this case was certainly indicative of a poor prognosis, as the earlier toxemia supervenes in the third trimester, the more severe it is likely to be.

The immediate cause of death in this patient was apparently an extensive bronchopneumonia. This is a serious hazard in comatose patients and should be combated vigorously. The typical pathologic anatomy of eclampsia was absent at autopsy, but this does not rule out the diagnosis, as all degrees of anatomical change have been observed in clinically well-documented eclampsia, including no characteristic lesions at all. Ordinarily, one would expect periportal hepatic necrosis and hyalinization of the basement membrane of the renal glomerular tufts, as well as diffuse cerebral edema and other evidences of generalized vasospasm. However, the diagnosis of eclampsia is a clinical rather than a pathologic one, and is to be made whenever a patient demonstrates two or more of the triad of hypertension, albuminuria and edema in the third trimester of pregnancy, and then exhibits grand mal seizures followed by coma. The patient reported fulfilled these criteria.

Eclampsia

Since eclampsia is a disease of unknown etiology, its treatment is empiric, and this should be directed toward reduction of vasospasm and minimization of convulsions. It has been shown that the prognosis is fairly directly related to the number of convulsive seizures. Morphine, not ordinarily an effective anticonvulsant, has proved effective in a large number of cases of eclampsia in reducing the convulsive tendency, and hence was used in

this case. The sedative effect of the magnesium ion is also a useful adjunct.

A special point in the treatment of convulsive toxemia is the fact that barbiturates are specifically contraindicated in this condition. Hence, the almost universal habit of administering intravenous sodium amytal to convulsing patients is one which must be resisted when there is any question of eclampsia. There are many well-documented cases of sudden fatal pulmonary edema following intravenous sodium amytal in such patients.

Despite modern medical advances, eclampsia continues to be a serious complication of obstetrics, carrying a mortality rate of 10 to 15%. It is especially prone to occur in previously hypertensive patients, who have an increased tendency when pregnant to develop severe toxemia early in the third trimester. The proper application of meticulous antepartum care started early in pregnancy and continued throughout is the most effective available means of reducing the incidence of this serious complication. The patient reported here was remiss in not seeking prenatal care at the onset of her pregnancy.



The Kentucky State Medical Association

Supports

DIABETES DETECTION WEEK

November 11 – 17

SPECIAL ARTICLES

Our Political Obligations— 1962 KSMA Presidential Address

GAITHEL L. SIMPSON, M.D.

Greenville, Ky.

ONE of the prime obligations of a citizen in a democracy — a government of the people, for the people and by the people — who is qualified to vote, is to exercise his right of petition. It is assumed that each individual will acquaint himself with the political issues involved, weigh the available evidence as relates to the qualifications and performance records of a particular candidate, and vote for and otherwise actively support the individual of one's choice.

He should also be willing to make the necessary sacrifices of time and resources to actively serve in public office, if particularly qualified, and if requested to stand for election. This is the ideal performance of the citizen, in its simplest form, so far as political obligation is concerned.

We Ignore Candidates' Philosophy

Too often we tend to adopt the party affiliation of our forefathers and shamefully vote a straight party slate almost regardless of the philosophy of the given candidates.

What is the usual picture of participation in community political activity of the average physician? Traditionally he receives a technical, scientific education, and often is unwilling to express his political beliefs because of the probability of offending patients of differing political party affiliations. Actually, many of us have hidden behind this cloak of non-participation because of an inexcusable and calloused apathy toward this basic civic duty, and there are a considerable number who do not properly qualify to participate because of improper registration.

We can no longer enjoy the luxury of illogical— or non-participation if we wish to effectively express our conservative sentiments. Since we as a profession have failed to provide active and effective leadership in legislative affairs which pertain to medicine, forces whose philosophies are not necessarily consonant with ours, have assumed to speak for us in instances which should more properly, at least, be guided and directed by us into acceptable lines consistent with our traditions.

For several years, actually 12 to 15, certain groups in the federal government have attempted to make political hay by offering our services to certain portions of the electorate, at the taxpayers' expense, and by some degree of compulsion toward both the patients and our members.

Efforts in 87th Congress

Specifically, during the 87th Congress, we and other groups of individuals, who cherish liberty and freedom and a continuation of the free enterprise system in America, have been joined in a serious struggle with strong forces in our Nation's Capitol who have attempted to establish a token medical care program for certain elderly people, within the framework of the Social Security Law. To date, this attempt has failed. There is every indication, however, that there will be a renewed effort to establish some program similar to the King-Anderson measure in the 88th Congress.

In this hiatus in the struggle, let us observe the issues involved and the relative position of the combatants at this time and discuss a proper course of action for our profession in the coming year.

The issue is one of providing a commodity to a large group of our fellow citizens at an unknown cost, and totally aside from the economic ability of many of these people, to provide medical service for themselves and at no cost to the taxpayer. It is our feeling that:

1. This measure is primarily motivated by a 1960 Presidential campaign promise.
2. The quality of the medical service rendered in this type of program would almost certainly deteriorate, because of third party intervention.
3. There will be abuse of the program by the patient because of the "something for nothing" philosophy, which is foreign to our democracy.
4. That the program will likely be extended each year, both vertically and horizontally, as it has in the parent Social Security System.
5. Ultimately, the Social Security System may be unable to support this expensive program and resources from the general fund will be required as a supplement. This is true in Europe now.
6. The greatest and most undesirable feature in this program is the inherent likelihood that this is but another step in the direction of a large and expanding central government, and that other professions and groups will be encompassed in similar mechanisms at a later date.

Pressure Has Increased

The pressure to establish this program increased terrifically in intensity over the past 24 months. It was defeated, or possibly only delayed, by an all-out effort on the part of organized medicine with the assistance of many individuals and groups outside our profession, who believe as we do, that the greatness of this Nation was largely founded on a basis of liberty and freedom, and especially an atmosphere in which the free enterprise system, not only as affects the medical profession, but as applies to other groups, such as agriculture, industry, etc., might flourish and grow without excessive intervention from the Central Govermnent.

Organized medicine has shown — however late — that it can be effective in arousing sentiment in Congress and elsewhere against changing the voluntary atmosphere in which we have functioned so successfully, into one of compulsion, thus saying, in effect, that we are willing to assume the necessary degree of leadership to direct our affairs.

If there is a solution to our dilemna it will lie in the province of strong leadership, not only by the AMA, but by each component state society. This is only a faltering first step. What specific steps should we propose to make our program effective? These are a few which we should consider, there are many others:

Steps To Make Program Effective

1. a. Encourage wide spread participation in prepaid private medical insurance plans.
   b. Connecticut last year, and Tennessee recently, have arranged for the insurance industry of their respective states to secure favorable legislation as regards trust laws to formulate and offer attractive comprehensive plans to the elderly at acceptable premium rates
   c. Emphasis should be placed on providing coverage for the catastrophic illness which may severely dissipate the savings of those who no longer are profitably employed.
2. a. Let us wholeheartedly support the Kerr-Mills program, and, in our instance, there are many inequities in the program which will be improved by constructive suggestions from our members to and through our advisory group and by more adequate appropriation from the General Assembly in succeeding years.
   b. Enthusiastically support AMPAC and KEMPAC.
3. Let us continue to wholeheartedly support our public and school health programs.
4. The Athlete Injury Prevention conferences which are being so capably implemented by us now.
5. Industrial medicine, even in the small plants, should be developed by our participation and encouragement.
6. Farm safety and accident prevention should not be neglected. The annual toll of killed and injured in the agricultural industry is appalling.
7. The activities of our highway safety program should have the enthusiastic support of all of us. The various committees charged with the responsibility of these facets of health and accident prevention cannot accomplish the maximal benefits alone.

How to Participate In Politics

What can and should the individual physician do to effectively participate in practical politics? Politics is defined as the science of government and it is not a dirty word.

Many of us have felt that an occasional letter to our Congressman and frequent and heated bull sessions in the hospital staff room where we are talking, almost without exception, to a fellow conservative, is the proper way to exert pressure. This is far from true. Often we do not know our Congressman personally and have made no effort to do so. Frequently, our only contact with him is in the form of opposition to some measure being considered. We seldom commend him when his views coincide with ours, and we occasionally fail to appreciate the fact that he cannot always vote with our sentiments.

The proper way to become acquainted with the legislator is to know him when he is selected for office. Of course, it is impossible for each physician to know the prospective legislator, but almost certainly he would come from a district in which a physician lives and should be not only participating in the public affairs of the community, but actually assisting his fellow citizens in selecting the proper type of citizen for a legislator.

It has been stated that the proper place to make one's influence felt politically is at the grass roots level. If this be true, then one should participate most actively in his own precinct. There is always an organization of each of the two major parties in each precinct. These are some ways in which one may effectively participate:

1. Attend the public meetings at which the organization of the precinct is set up. Make a concerted effort, along with other intelligent citizens, to be certain that the officers are of the proper type so far as citizenship is concerned.
2. Be willing to serve as a precinct officer if so requested.
3. Assist in keeping the voter's census of the particular precinct current.
4. Visit with and discuss issues with the voters in your local area if they have medical implication.
5. Offer to serve as a poll's official in one of the various capacities necessary on election day.
6. Offer to assist in transportation of voters to the polls where they do not have transportation or are unable to provide it for themselves.
7. Last but not least, be willing to contribute financially to the party and candidate of your choice.

Action on Local Level

These are but a few of the elementary, but very necessary, ways in which an interested individual may participate at the local level in the political affairs of his community. After the legislator has been selected, the alert citizen should visit him and become acquainted with him in his home, if possible, and after he reports to the state or national Capitol to participate in legislative affairs, we should keep in constant contact with him, supporting him when he needs support and offering constructive criticism if we have reason to believe that he is deviating from the manner in which he should be progressing. If to some of you, who are more sophisticated in political activities, these simple admonitions appear unduly elementary, let me remind you that it may be later than you think so far as the maintenance of our basic freedoms are concerned.

I have been trying to say that every physician and his wife should actively and enthusiastically participate in the science of democratic government at the precinct level first, and elsewhere secondly.

Aside from political matters, that affect us primarily in our profession, I would call to your attention the profligate manner in which the national government conducts the fiscal affairs of this country, with total disregard to the national debt, balancing the budget, etc.

I call your attention to Benjamin Franklin's biography and the writings of Thomas Paine. After reading these two publications within the recent past, I am quite thoroughly convinced that very few of us are aware of the price which our forebears paid for the liberties which we enjoy and which we are rapidly losing to a government which is almost as dictatorial as was that in England preceding the Revolutionary War.

As a final thought, I will leave this quotation with you from Abe Lincoln who said, "You cannot bring prosperity by discouraging thrift. You cannot strengthen the weak by weakening

(Continued on Page 1107)

EDITORIALS

John Walker Moore, M. D.

TEN YEARS have passed—it was on November 10, 1952 that John Walker Moore, M.D., died in Louisville.

The chronological events of his life are these: He was born in McConnellsville, South Carolina, January 29, 1884. He received a B.S. Degree at Davidson College in 1906. For two years he studied medicine at the University of North Carolina and then transferred to the University of Pennsylvania where he graduated with the degree of M.D. in 1912. He took his internship and residency at the Episcopal Hospital in Philadelphia.

In 1915 he came to the University of Louisville as instructor in pathology where he remained until the outbreak of the first World War. He was in the Army from 1917-1919 spending much of his time overseas in charge of laboratories.

At the end of the war in 1919 he returned to the University of Louisville as instructor in medicine. The following year he was made professor of medical research. In 1923 he became professor of medicine and chairman of the Department of Medicine. In addition to his teaching duties he was engaged in private practice from 1923-1929 when he became dean of the University of Louisville School of Medicine. He retired from this position in 1949 and was appointed the Alben W. Barkley Professor of Medicine, which position he held until 1952.

Doctor Moore was an outstanding figure in medicine locally and nationally. In 1940 Davidson College conferred upon him the honorary degree of Doctor of Science. In 1949 the University of Louisville conferred upon him the honorary degree of Doctor of Law. In 1943 he was president of the Central Society for Clinical Research. In 1945 he was president of the Association of American Medical Colleges.

He became a Fellow of the American College of Physicians in 1922 and continued a very active participation in the affairs of this organization throughout his professional career. He was a member of many other national associations concerned with internal medicine and research.

During his more than 30 years of teaching at the University of Louisville School of Medicine, Doctor Moore came in intimate contact with some 2,000 medical students in their formative period, and it is reasonable to state that the imprint of his personality and influence was left in some degree upon every one of them.

It is difficult to analyze what constitutes a great teacher. Perhaps as good a criterion as any would be: First, the respect and esteem with which his students hold him and, second, how well do his teachings bear the test of time and experience for the students. Judged by these two criteria Dr. Moore was a great teacher of medicine.

Few who heard him would claim that he was a great lecturer. His method was simple, direct and quiet, reviewing thoroughly the recorded knowledge concerning his subject and flavoring it well with his own clinical experience and observations; but his greatest influence was exerted as an instructor on the wards and at the bedside rather than in the lecture room. It was here that his influence upon his students was fixed and indelible. There are physicians in perhaps every state in the union and over the entire world who will recall vividly and with pleasure his ward rounds and bedside teaching.

Doctor Moore was interested in research and throughout his career as teacher was carrying on some investigation, usually pertaining to cardiac disease and circulation. His method of measuring circulation time became a useful instrument in the hands of many other investigators; but, more important, by precept and example he impressed upon his students the value of some research to be carried out in their daily practice.

Doctor Moore's deanship covered two long

and trying periods, the severe depression of 1929-1940 and the hazardous postwar period. During the war a greatly accelerated tempo of teaching was required to increase the output of physicians. This had to be done with a depleted faculty; the physical and mental strain of these years no doubt shortened his life. His diligent effort and his acquaintance with influential friends throughout the state tided the School of Medicine over the postwar crisis.

He was able, for the first time, in 1948 to secure an appropriation from the state legislature which literally saved the Medical School and which since has been increased in amount from year to year. His efforts more or less firmly established this private school as at least a partial responsibility of the state government.

The influence of Doctor Moore as administrator, dean and as advocate of the school before the political rulers of the city and state was surely one of his major contributions. He, with others, was influential in bringing to Louisville a group of well-trained young men from other medical centers who were badly needed at the time to bolster the academic strength of our school. These men have, during the past generation, exerted a most favorable influence in elevating the level of teaching and medical practice in this state. Among them was his successor, our present dean, J. Murray Kinsman, M.D.

At the time Doctor Moore became dean a considerable amount of dissension and professional jealousy was apparent among the physicians of Louisville and Kentucky, and his influence more than any other one man that we know, bridged the chasm, quieted the dissension, smoothed the turbulence, and built up a spirit of cooperation and mutual trust between the physicians in private practice and those connected with the School. It was rare that any of his associates heard him speak in other than complimentary terms of a colleague.

The medical atmosphere in Louisville is perhaps as pleasant as in any other city in the United States. The influence of John Walker Moore, M.D., undoubtedly contributed as much toward this warm spirit of fellowship and cooperation as any other factor.

Several memorials have been established in his honor. The most lasting, and the one that he would better cherish, is the daily practice of his precepts and example in the hearts of his students, interns and residents.

Sam A. Overstreet, M.D.

Infectious Diseases — 1962; The Value of Objectivity*

THE year 1962 marks the 80th anniversary of Robert Koch's discovery of the human tubercle bacillus.[1, 2] This accomplishment, important as it was in the advancement of the knowledge of tuberculosis, had a truly revolutionary impact upon the study of all infectious diseases. Although the tubercle bacillus, identified for the first time under Koch's microscope, was the immediate reward, the experimental methods which he devised to obtain the organism in pure culture and the proof of its causal relationship to the disease in man were of profound significance. It was largely on the basis of the logical sequence of his evidence that bacteriology acquired the scientific basis which almost immediately led to the proof of the etiology of many other bacterial diseases. Thus for the first time the physician could identify the etiologic agent in an important group of diseases.

The basic importance of Koch's experimental approach to provide unequivocal proof of a suspected causal relationship between a bacterium and a particular disease led to the formulation of a series of postulates:[3]

(1) The bacterium must be observed in every case of the disease.

(2) The bacterium must be isolated and grown in pure culture.

(3) The bacterium, in pure culture must, when inoculated into a susceptible animal, give rise to the disease.

(4) The bacterium must be observed in and recovered from the experimentally diseased animal.

Although these criteria were not stated explicitly by Koch they were inherent in the scientific proof of a specific (bacterial) etiology and were soon referred to as Koch's postulates.

The above editorial, which arrived too late for inclusion in the October KSMA Journal, is written by Beverly T. Towery, M.D., who is 1962 Symposium Editor of The Journal. Doctor Towery is professor of medicine and chairman of the Department of Medicine of the University of Louisville School of Medicine. The Symposium on "Infectious Diseases" appeared in the October Journal.

The value of these observations was rapidly confirmed by numerous investigators and many notable discoveries enlightened the medical scene. Whenever Koch's postulates were fulfilled a scientific basis was established to permit rapid progress in the study of the pathogenesis, epidemiology and immunologic characteristics of this disease in question. Furthermore this knowledge was fundamental to the prevention of disease and to the eventual discovery of potent therapeutic agents.

Once the specific etiology of a given disease had been established by such experimental evidence an immediate practical advantage was achieved in the care of patients suffering from bacterial infections. Assuming strict adherence to objective observations the physician could, when confronted by a given clinical problem, obtain laboratory evidence of great diagnostic precision. These isolated observations were not a formal repetition of Koch's postulates but were validated by their prior fulfillment.

Among the many examples of scientifically incomplete but extremely valuable diagnostic data one may recall a few of great practical significance: The presumptive identification of the diphtheria bacillus in nasopharyngeal smears and its isolation in pure culture; similar identification and recovery of the Group A hemolytic streptococcus; the dark-field demonstration of T. pallidum from the chancre of primary syphilis; the recognition of the typical gram negative intracellular diplococcus in urethral smear; the demonstration of acid-fat bacilli in sputum, spinal fluid or exudate; the rapid identification of the pneumococcus by the Quellung reaction with type-specific antiserum; recovery of the meningococcus from the skin lesions in meningococcemia; the establishment of an etiologic diagnosis in bacterial endocarditis by appropriate blood cultures.

The nature of each bacteriologic procedure depended primarily upon the clinical characteristics of the disease but was designed to identify the pathogenic organisms with assurance so that an etiologic diagnosis could be established with confidence even though strict conformity with Koch's postulates was only inferential. In most instances the supporting laboratory evidence could be obtained quickly and the presumptive identification of the infectious agent could be confirmed promptly by a study of its morphologic and cultural characteristics. It was Koch who had shown that semi-solid culture media greatly facilitated the isolation of bacteria in pure culture.

Despite its initial outstanding success, clinical bacteriology has suffered serious attrition during recent years. This fact is due mainly to the growing importance of pathogenic viruses and to the discovery of highly potent antimicrobial agents for the treatment of bacterial infections. In the first instance direct proof of a specific virus etiology usually cannot be demonstrated immediately and the correct diagnosis can only be surmised on the basis of epidemiologic evidence or proved in retrospect on the basis of immunologic data or ultimate virus isolation.

The antimicrobial era has unfortunately fostered the attitude that an exact etiologic diagnosis is no longer essential. Such an approach in the treatment of infectious diseases carries with it a high probability of error. The Symposium presented in the October issue of The Journal provides clear evidence for the validity of the principles established by Koch and it is hoped that every physician will reaffirm his reliance upon these basic facts. If this is done medicine can confidently expect further progress in the control of infectious diseases regardless of the nature of the causative agent.

Beverly T. Towery, M.D.

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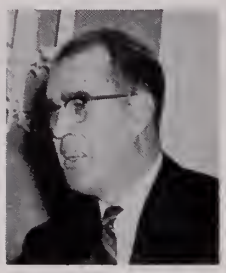
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ORGANIZATION SECTION

George P. Archer, M.D., Is Named KSMA President-Elect

George P. Archer, M. D., Prestonsburg, was chosen president-elect of the Kentucky State Medical Association by the House of Delegates at the Annual Meeting of the Association at Louisville, September 18-20. David M. Cox, M.D., was installed as president succeeding Gaithel L. Simpson, M.D., Greenville, retiring president.



Doctor Archer

Doctor Archer, a native of Paintsville, was graduated from the University of Louisville School of Medicine in 1941 and started practice at Paintsville in 1946 after serving in the U.S. Air Force with the rank of major. He moved his practice to Prestonsburg in 1942.

In 1948 Doctor Archer was active in forming the Eastern Kentucky Hospital Council and was a charter member and first secretary of the Kentucky Academy of General Practice. In 1958 he served the KAGP as vice president.

Doctor Archer has served the KSMA as delegate to the AMA and before that as alternate delegate. In 1960 he received the Distinguished Service Award. He is a former chairman for national affairs of the KSMA Council on Legislative Activities and is a past president of the Floyd County Medical Society.

Vice presidents elected at the Annual Meeting are: Alfred O. Miller, M.D., Louisville, (Central); Hugh Mahaffey, M.D., Richmond (Eastern); Joseph R. Miller, M.D., Benton (Western.)

Robert C. Long, M.D., Louisville, was reelected delegate to the American Medical Association, and Wyatt Norvell, M.D., New Castle, was named delegate to fill out the unexpired term of the president-elect, Doctor Archer. J. Thomas Gianinni, M.D., Louisville, was reelected alternate delegate.

Join and Support AMPAC, KEMPAC, Says Doctor Blasingame

A strong appeal to physicians to join and work with and for the American Medical Political Action Committee and the Kentucky Education and Medical Political Action Committee—more familiarly known as AMPAC and KEMPAC—was sounded by F. J. L. Blasingame, M.D., Chicago, at the 1962 Annual Meeting of the Kentucky State Medical Association.

Doctor Blasingame, executive vice president of the American Medical Association, was the featured guest speaker at the President's Luncheon, September 19.

"Politics," he said, "is a laudable undertaking. We are winning but we owe it to the American public to stand up and be counted. Our adversaries are bankrupt for new ideas. We must act vigorously and with promptness."

Doctor Blasingame said the political outlook for the medical profession is good and, pointing out that the King-Anderson bill has been defeated, he said public sentiment is swinging increasingly behind the medical profession's stand.

If medical care proposals come up in the next Congress, and they probably will in modified form depending on the outcome of the November elections, the medical profession will again oppose them vigorously, he said.

The increasing emphasis on public health was noted by Doctor Blasingame who commended particularly the provision of funds for new hospitals and other medical facilities, but he warned that no "third party" should come between physicians and their patients.

In noting the increase in medical costs, he said that quality of medical care has also risen and that no people in the world get the high quality of medical



F. J. L. Blasingame, M.D., Chicago, executive vice president of the American Medical Association, addresses the President's Luncheon during the Annual Meeting of the Kentucky State Medical Association at Louisville September 19.

care that is available to residents of the United States. He pointed out that this country has become the international center for medical education with some 10,000 foreign physicians training here.

A note of warning about government proposals in the field of medical care was sounded by Doctor Blasingame who said: "Our principal adversaries want socialized medicine—make no mistake on that, however they cloak it. That is the heart of the matter. They want to control medicine.

"Modern government has gotten to be the tool of modern slavery. More people live in slavery now than ever in history and invariably it is under Government control in the name of the public interest."

Doctor Sweeney Elected Speaker; Doctor Brockman Named

Garnett J. Sweeney, M.D., Liberty, was named speaker of the House of Delegates of the Kentucky State Medical Association at the Annual Meeting, September 18-20 at Louisville, succeeding Sam A. Overstreet, M.D., who was elected speaker at the 1959 Annual Meeting.



Doctor Sweeney

Doctor Sweeney was formerly vice speaker and was elected to that office also in 1959.

George F. Brockman, M.D., Greenville, was named vice speaker of the House of Delegates.

Doctor Overstreet, a 1923 graduate of the University of Louisville School of Medicine is editor of The Journal of KSMA and has served in that capacity since 1958. He served as KSMA president in the Centennial year, 1951, and has also been president of the Jefferson County Medical Society. He is governor of the Kentucky Chapter, American College of Physicians.

Doctor Sweeney served as trustee from the 12th District for six years and was its chairman one year. He was president of the Kentucky Academy of General Practice in 1954. He was graduated from the University of Louisville School of Medicine in 1939 and has practiced at Liberty since 1940. He is a former chairman of the KSMA Committee on Medical Education.

Doctor Brockman is chairman of the KSMA Building Committee, which planned and took charge of construction of the new KSMA Headquarters Building. He was appointed a delegate to the American Medical Association in April 1961 and served through December of that year. He has been a physician at Greenville since 1946. He was graduated from the University of Louisville School of Medicine in 1935.



Doctor Overstreet



Doctor Brockman

Doctors Smith and Glenn Named by Board of Trustees

Keith P. Smith, M.D., Corbin, trustee from the 15th District, was elected chairman of the Board of Trustees of the Kentucky State Medical Association at the Annual Meeting, September 18-20, at Louisville. He succeeds Wyatt Norvell, M.D., New Castle, who was named delegate to the American Medical Association. John P. Glenn, M.D., Russellville, trustee from the Sixth District, was named vice chairman.



Doctor Smith

New trustees elected by the House of Delegates were: O. Leon Higdon, M. D., Paducah, First District, and Gabe A. Payne, Jr., M.D., Hopkinsville, Third. Reelected were: Dixie E. Snider, M.D., Springfield, Fourth District; Thomas O. Meredith, M.D., Harrodsburg, 12th, and William C. Hambley, M.D., Pikeville, 14th.

Doctor Higdon succeeds Hugh L. Houston, M.D., Murray, in the First District, and Doctor Payne succeeds Ralph D. Lynn, M.D., Elkton, in the Third.

UMW May Close 4 Ky. Hospitals If Not Sold or Leased

The United Mine Workers may close its four Kentucky hospitals if they are not sold or leased to other groups or communities, said the administrator of one of the hospitals at Hazard, according to published reports the week of October 16.

The four hospitals are at Hazard, Middlesboro, McDowell and Whitesburg. According to reports, a spokesman for the Miners Memorial Hospital Association which operates the hospitals in Kentucky and others in Virginia and West Virginia, said that from the time the hospitals were built in 1956 it had been hoped they would one day become community facilities.

Hospitals In 3 States Involved

An announcement October 12 by the UMW Welfare and Retirement Fund said it is attempting to get transfer to local communities of all 10 hospitals in the three-state area now operated by the union. A spokesman was reported to have said the hospitals in Kentucky would be closed only as a last resort and that an all-out effort was being made to interest community, civic, public, private and church groups to take over and operate the hospitals.

According to the report, the union is seeking to dispose of the hospitals because the Union's beneficiary population is decreasing.

Mass Oral Polio Immunization Plans Move Forward in Kentucky

A total of 1,383,225 immunizations with Sabin polio vaccine have been given in 42 counties of Kentucky as of October 18, according to figures provided by J. Clifford Todd, M.P.H., state epidemiologist with the Kentucky State Department of Health, Frankfort. Mr. Todd pointed out that figures are not yet available from some counties where immunization programs have already started. These would increase the total still more.

In these 42 counties, 993,155 immunizations of Type I vaccine have been given; 214,809 with Type II and 195,261 with Type III, Mr. Todd said.

The program now underway in Kentucky calls for urging every county to sponsor such a program, according to Mr. Todd, and efforts are being made to contact those persons in each county who would sponsor such a drive.

In some counties, he said, preliminary programs which immunized just school children, are now being expanded to include the entire population. Once a high immunization with the Sabin vaccine has been achieved, he pointed out, it will be recommended that the Salk shots need not be given.

Mr. Todd said that there have been 22 cases of polio reported in Kentucky in 1962 as contrasted with 28 in 1961—of which 13 had their origin in the preceding year, 1960—reducing the 1961 total to 15.

KSMA Awards Presented At President's Luncheon

Three new awards were made along with those established by custom, at the President's Luncheon during the Annual Meeting of the Kentucky State Medical Association at Louisville, September 18-20.

The Distinguished Service Award was presented to Mitchel B. Denham, M.D., Maysville. He was nominated for the award by the KSMA Council on Legislative Activities for State Affairs.

The Council noted his work as state representative from the 65th district where, in the Legislature, he worked to defeat bills not in the public interest and rendered invaluable service in passing those which would benefit the public.

Doctor Denham was graduated from the University of Louisville Medical School in 1940 and is a veteran of the U. S. Army Medical Corps. He has headed the Kentucky Rural Health Council and the KSMA Rural Health Committee.

John P. Walton, M.D., 80, Central City, received the Outstanding General Practitioner Award. He started practice at Central City in 1908 and in his 54 years of practice has delivered an estimated 6,000 Muhlenberg County babies.

Doctor Walton was instrumental in the establishment of the Muhlenberg Community Hospital and the Greenville Cancer Clinic. He has been honored by civic groups in his community for his work.

Miss Dorcas Ruthenberg, public affairs director



Recipients of KSMA Annual Awards are congratulated at the President's Luncheon during the KSMA Annual Meeting, by William H. Bizot, M.D., (center) chairman of the Awards Committee, and F. J. L. Blasingame, M.D., (right) Chicago, luncheon speaker and executive vice president of the American Medical Association. Left to right: Mitchel B. Denham, M.D., Maysville, winner of the Distinguished Service Award; Miss Dorcas Ruthenberg, Louisville, WHAS Radio public affairs director, winner of the R. Haynes Barr Award; Doctor Bizot; John P. Walton, M.D., Central City, winner of the Outstanding General Practitioner Award, and Doctor Blasingame.



S. Spafford Ackerly, M.D., (right) professor of psychiatry and chairman of the Department of Psychiatry, University of Louisville School of Medicine, receives the U. of L. Faculty Award for 1962 from KSMA President Gaithel L. Simpson, M.D. A similar picture was taken of Edmund D. Pellegrino, M.D., professor of medicine and chairman of the Department of Medicine at the University of Kentucky College of Medicine, who received the U. of K. Faculty Award from KSMA but it could not be printed because of equipment failure. The Awards were made for the first time at the 1962 Annual Meeting of KSMA.

for WHAS Radio, received the R. Haynes Barr Award. She was cited for her work with health and rehabilitation organizations, including the Governor's Advisory Committee on Rehabilitation, the Advisory Council of Bridgehaven, the Kentucky Heart Association, the Kentucky Health Council and the Kentucky Welfare Association. Many WHAS radio programs for which she has been responsible, have served the cause of health.

The KSMA established and presented the first Awards to an outstanding faculty member of each of Kentucky's two medical schools. The 1962 Award for the University of Louisville went to S. Spafford Ackerly, professor of psychiatry and chairman of the Department of Psychiatry.

In the citation it was noted that Doctor Ackerly, who has been at U. of L. since 1932, was instrumental in leading the drive for a special wing at the Norton Memorial Infirmary to house private psychiatric patients, and that he had done much in aiding the development of psychiatric service at the Louisville General Hospital, Veterans Hospital and the Child Guidance Clinic. It also noted his contribution to the cause of Mental Health throughout the State and nation.

Edmund D. Pellegrino, M.D., Lexington, professor of medicine and Chairman of the Department of Medicine at the University of Kentucky College of Medicine, was 1962 recipient of the Award for U. of K.

His citation noted his interest in continuing education for the practicing physician; his contributions to the philospophy of education and patient care at the Medical Center, and his continued service in the research laboratory, plus his assistance in the development of good relations between the U. of K. and the medical profession.

An exhibit on "Cancer of the Colon and Rectum" received the Scientific Exhibits Award—also a new award. The exhibit was prepared by Coleman C. Johnston, M.D., James T. McClellan, M.D.; Duvon C. Corbitt, M.D., and Robert E. Stam, M.D.,—all of the University of Kentucky Medical Center.

Kennedy Signs Pension Bill To Permit Tax-Deductible Plans

The bill permitting self-employed persons to set up tax-deductible pension plans was signed by President Kennedy October 10. Only an hour before Congressional leaders had predicted the bill would become law without his signature. It becomes law January 1. (See Washington News Digest page 1106.)

The bill was passed by the House of Representatives four times before being passed by the Senate which added several amendments.

In brief, the new law allows a self-employed person who owns more than 10% interest in his business to invest up to 10% of his earnings, not to exceed $2,500 a year, in a personal pension system and he may deduct half of the contribution, with a maximum of $1,250 a year, from his current taxable income.

However, the law provides that if the self-employed individual employs anyone else in his business he must establish a comparable plan for his employees to get the tax benefit for himself. It is estimated the bill will benefit as many as 7,000,000 self-employed persons and 11,000,000 of their employees.

U. of L. Eye Institute To Be Outstanding in U. S.

The ophthalmology center for research, teaching and treatment being completed at Louisville by a team of University of Louisville physicians and researchers seems destined to become one of the outstanding eye institutes in the United States and, according to J. Murray Kinsman, M.D., dean of the U. of L. Medical School, "will certainly gain national reputation and, eventually international recognition."

C. Dwight Townes, M.D. head of the Medical School's section on ophthalmology, who has long envisioned the plan, is being assisted by Warren Dennis, Ph. D., biophysicist, and Roderick Macdonald, M.D., ophthalmologist researcher, in establishing the center. Doctor Dennis is director of ophthalmic research, and Doctor Macdonald, associate professor and executive director of the section of ophthalmology.

The institute is located in a large portion of the fourth floor of the old Reynolds Metals Company Building in Louisville near the U. of L. campus.

Financial support has been furnished by the Kentucky Lions Eye Foundation whose eye bank is installed at the new center; the National Institute of Health; the National Society for the Prevention of Blindness; the American Heart Association; Knights Templar Eye Foundation, and others.

Endocrine Concepts Subject of 1962 Norton Seminar

"Present Day Endocrine Concepts in Medicine and Surgery" is the subject for the Fifth annual Norton Memorial Infirmary postgraduate medical seminar to be held December 13 at Louisville. Co-sponsor is the Kentucky Chapter of the American Academy of General Practice.

Subjects and speakers are as follows:

Hormone Overproduction Syndromes: Surgical Consideration—David W. Kinnaird, M.D., instructor in surgery, University of Louisville School of Medicine.

Endocrine Basis of Fibrocystic Disease of the Breast—George B. Sanders, M.D., professor of surgery, U. of L.

Hormonal Therapy of Disseminated Carcinoma of the Breast—Henry S. Collier, M.D., instructor in surgery, and R. Arnold Griswold, M.D., professor of surgery, U. of L.

Hysterectomy and Hormones—Laman A. Gray, M.D., associate professor of obstetrics and gynecology and associate in pathology, U. of L.

Diagnostic Enzymology—Malcolm L. Barnes, M.D., associate professor of pathology, U. of L.

Endocrine Problems Associated with Abnormal Sexual Development—Raymond G. Bunge, M.D., professor of urology, University of Iowa School of Medicine, Iowa City.

Oral Contraception: To Use Or Not To Use—William C. Durham, M.D., instructor in obstetrics and gynecology, U. of L.

Thyroid Therapy—James Robert Hendon, M.D., assistant professor of medicine and chief of the section on endocrinology, U. of L.

Use and Abuse of Cortico-steroids—William P. Peak, M.D., instructor in medicine, U. of L.

Present Day Therapeutic Concepts of Inoperable Carcinoma of the Prostate—Doctor Bunge.

Hormones and Osteoporosis—Robert S. Tillett, M.D., instructor in medicine, U. of L.

Steroids and the Treatment of Ear Diseases—Alex M. Forrester, Jr., M.D., professor of otorhinolaryngology, U. of L.

Long Term Steroid Therapy: The Problem It May Pose for the Anesthesiologist—Eugene H. Conner, M.D., professor of anesthesiology and chief of the section on anesthesiology, U. of L.

Ophthalmic Clues in Endocrinopathies—Charles O. Bruce, M.D., instructor in ophthalmology, U. of L.

James W. Davis, M.D., Louisville, vice speaker of the House of Delegates of the Kentucky Chapter, AAGP, will open the session and tell the aims of the seminar.

Presiding at the morning session will be: J. S. Williams, M.D., Lexington, president of the Kentucky Chapter, AAGP, and in the afternoon, William A. Bledgett, M.D., Louisville, president of the staff of Norton's.

Dr. Wood Heads Orthopaedists

Charles F. Wood, M.D., Louisville, was elected president of the Kentucky Orthopaedic Society at its meeting at Louisville, September 18. Thomas D. Yocum, M.D., Lexington, was named vice president and William C. Mitchell, M.D., Louisville, secretary.



With his wife and surrounded by his colleagues, C. C. Howard, M.D., Glasgow, is pictured above immediately following a luncheon honoring him October 21 (see next page.)

Seated, left to right are: David M. Cox, M.D., Louisville, KSMA president; Mrs. Howard, Doctor Howard and Gaithel L. Simpson, M.D., Greenville, immediate past president of KSMA. Standing, left to right, John P. Glenn, M.D., Russellville, KSMA trustee, Sixth District; Sam A. Overstreet, M.D., Louisville, KSMA Centennial president and editor of The Journal of KSMA; Robert W. Robertson, M.D., Paducah, KSMA past president; Arcy O. Miller, M.D., Scottsville, recipient of KSMA Outstanding General Practitioner Award in 1955; Hugh C. Houston, M.D., Murray, past KSMA president; Paul S. York, M.D., Glasgow, who presided; John Dickinson, M.D., Glasgow, president of the Kentucky Physicians Mutual; J. Duffy Hancock, M.D., Louisville, past president of KSMA and Dixie E. Snider, M.D., KSMA Fourth District trustee.

KSMA Resolution Salutes 50 Years Of Practice for Dr. Howard

October 21 marked the 50th anniversary of medical practice in Glasgow, Ky., for Carl C. Howard, M.D., which was celebrated with a special observance by the people of the Glasgow community. Friends from all over the State attended the affair. (See picture on page 1068).

In honor of the occasion the executive committee of the Kentucky State Medical Association passed the following resolution:

"WHEREAS, Carl C. Howard, M.D., has practiced in Glasgow for the past 50 years, and the Glasgow Community is observing this anniversary on October 21, 1962, and

"WHEREAS, Doctor Howard is the father of the Kentucky Tuberculosis Sanitaria systems, the Rural Kentucky Medical Scholarships Fund and has vigorously supported numerous other statewide projects in the public interest, and

"WHEREAS, Doctor Howard has faithfully served his family, his patients, his church and his community during these years, and

WHEREAS, Doctor Howard has served as President of the Kentucky State Medical Association, Chairman of its Council and represented it as Delegate to the AMA and was the first recipient of its highest award—the KSMA Distinguished Service Medal,

"NOW, THEREFORE BE IT RESOLVED, that the members of the Kentucky State Medical Association extend their congratulations and best wishes to Doctor Howard—one of Kentucky's most useful citizens on this happy occasion, and

"BE IT FURTHER RESOLVED, that the members of the KSMA express their appreciation to the citizens of Glasgow for making this occasion possible."

Doctor Teague Is Recipient Of A. T. McCormack Award

Russell E. Teague, M.D., M.P.H., Frankfort, Kentucky commissioner of public health, has received the A. T. McCormack Award presented annually for outstanding contributions in administration or research related to public health work.



Doctor Teague

The Award is made by the Association of State and Territorial Health Officers in memory of Doctor McCormack, who was head of the Kentucky State Board of Health and later the Health Department from 1912 to 1943, and served as secretary of the Kentucky State Medical Association from 1907 to 1943.

Doctor Teague is the first Kentuckian to receive the award which was established in 1950 to honor selected individuals with 25 years or more in public health work. The Association in making the Award, cited Doctor Teague's 31 years in public health.

He has been commissioner of public health since 1956 and was engaged in public health work in Kentucky, of which he is a native, from 1931 to 1945. He is a graduate of University of Louisville School of Medicine and received his master of public health degree from Johns Hopkins University.

President Kennedy Signs Bill Tightening Drug Controls

President John F. Kennedy October 10 signed legislation passed by Congress tightening the federal controls over the drug industry and the production and marketing of new drugs.

Under the new law, the Food and Drug Administration may suspend the use of any drug it feels carries an immediate health hazard. Other provisions: (A) Authorize government inspection of factories producing prescription drugs; (B) require drug manufacturers to prove the effectiveness as well as the safety of their products; (C) require drug firms to include "in brief summary" on advertisements the side effects, contraindications and effectiveness of their product; (D) require physicians to inform patients when they prescribe experimental drugs; (E) establish a system of standardized names of drugs; (F) set up new procedures under which experimental drugs can be withdrawn from use; and (G) require that the common or official name of the drug be printed on the label prominently in type at least half as large as that of the brand name.

KSMA Representatives to Attend AMA Winter Clinical Meet

Several members of the Kentucky State Medical Association have, as of this writing, made plans to attend the winter clinical meeting of the American Medical Association, Nov. 25-28 at Los Angeles.

Among those planning to go to Los Angeles are the KSMA delegates to the AMA: Robert C. Long, M.D., Louisville; J. Vernon Pace, M.D., Paducah, and Wyatt Norvell, M.D., New Castle. Alternate delegates are: J. Thomas Gianinni, M.D., Louisville; John C. Quertermous, M.D., Murray, and Carl C. Cooper, Jr., M.D., Bedford.

Also in the Kentucky party will be KSMA President David M. Cox, M.D., Louisville, and the president-elect, George P. Archer, M.D., Prestonsburg.

A total attendance of 12,000 is anticipated at the meeting, half of whom will be physicians. House of Delegates headquarters will be at the Biltmore Hotel; scientific sessions, at the Shrine Auditorium.

The scientific sessions will be concerned with: Air pollution and pulmonary disease; viral hepatitis; cineradiography; general surgery; clinical nuclear medicine; new approaches to depression and suicide; anesthesiology; thoracic surgery; disturbances of growth in children; etiology and pathogenesis of cancer; forensic medicine in clinical practice; urology; chemotherapy of cancer; neurosurgery; gynecology and obstetrics; management of cardiovascular disease; dermatologic surgery; viruses; aero-space medicine; orthopedics; ear, nose and throat.

Delegates Vote to Hold 1963 KSMA Meeting in Lexington; Consider Record Number of Resolutions in Harmonious Sessions

A record number of 16 resolutions and the reports of officers, councils and committees were considered by the 1962 session of the House of Delegates of the Kentucky State Medical Association at the Brown Hotel, Louisville, September 17 and 19, in a meeting marked by an absence of controversy.

The House voted to accept, with appreciation, a resolution from the Fayette County Medical Society inviting the Association to hold its 1963 Annual Meeting in Lexington, September 24, 25 and 26, if appropriate arrangements could be made. The Association has met continuously in Louisville since 1950. (In implementing the resolution, the Board of Trustees voted to appoint a committee—with power to act—to investigate the facilities at Lexington. The committee met October 6 in Lexington and after a thorough study of facilities voted to have the 1963 Annual Meeting there.)

The December issue of The Journal will carry the complete minutes of the House of Delegates' 1962 meeting which will include all reports, resolutions, reference committee recommendations and final actions.

In order to allow more time for consideration of reference committee reports and not meet in competition with the general scientific session, the House accepted a recommendation of the Board of Trustees that the first meeting would be at 9 a.m., Monday, September 23, instead of at 6 p.m., at which time the reports and resolutions would be introduced. The reference committees would meet at 2 p.m., that afternoon before the general session started Tuesday, September 24. The second meeting would be held as usual on Wednesday afternoon.

As a result of recommendations from the Board of Trustees and a resolution from the Campbell-Kenton



Pictured at the 1962 KSMA Annual Meeting at the first session of the House of Delegates at Louisville, September 17, are the chairmen of KSMA Councils. First row, left to right, Walter S. Coe, M.D., Louisville, chairman, Council on Medical Education and Hospitals; Gaithel L. Simpson, M.D., Greenville, president and chairman, Council on Scientific Assembly; Claude C. Waldrop, M.D., Williamstown, chairman, Council on Medical Services. Top row, left to right, J. Farra Van Meter, M.D., Lexington, chairman, Council on Allied Professions and Related Groups; Robert D. Shepard, M.D., Lexington, chairman of the Council on Legislative Activities for State Affairs and John C. Quertermous, M.D., Murray, chairman, Council on Legislative Activities for National Affairs; N. Lewis Bosworth, M.D., Lexington, chairman, Council on Communications and Public Services.



Wyatt Norvell, M.D., New Castle, left, chairman of the KSMA Board of Trustees, gives the oath of office to the new KSMA president, David M. Cox, M.D., Louisville, at the Annual Meeting at Louisville, September 18-20.

County Medical Society, the House voted to alter the Association's present program of postgraduate medical education and reduced the appropriation previously authorized to $5,000 a year. At the same time, Walter S. Coe, M.D., Louisville, chairman of the Committee on Postgraduate Medical Education, was highly complimented for his leadership.

The delegates considered a resolution from the Campbell-Kenton County Society asking for a study of reapportionment of the 15 trustee districts of the State. The House referred this resolution to the Board of Trustees for further study and a report.

Two resolutions were presented by the Muhlenberg County Medical Society calling on the House of Delegates to endorse the American Medical Association's rejection of compulsory social security for physicians in independent practice and asking the KSMA to make this information public. The second resolution expressed appreciation for leadership of the legislation not in the public interest.

The House also passed a resolution submitted by the Board of Trustees expressing lasting appreciation to the AMA for its leadership in resisting legislation of a socialistic nature and pledging the Association's continued effort to improve the nation's medical resources.

Reference Committee No. 5 called special attention to the report of the KSMA Committee on Aging, complimenting it highly and urging that each delegate bring it to the attention of his local county medical society.

The House expressed appreciation for the activities and good work of the Board of Directors of the Kentucky Physicians Mutual, which is the Blue Shield Plan for this State, and to the Board of Trustees of the Rural Kentucky Medical Scholarship Fund.

Three resolutions in the field of medical services were referred by the House of Delegates for further study. These included the Pike County and the Warren County resolutions relating to procedures under the indigent care program and the Douglas resolution which related to the exclusion of certain medical services from coverage in the proposed national Blue Cross plan for the aged.

The Jefferson County resolution commending the editors of The KSMA Journal and expressing appreciation for the work of the retiring associate editor, George W. Pedigo, M.D., Louisville, was accepted.

The Fayette County Medical Society resolution expressing appreciation for the work of the Woman's Auxiliary in the field of legislation was voted and a recommendation that the KSMA Building Committee should be continued for one more year was accepted.

Was Your Delegate Present?

ROLL CALL—1962 House of Delegates* KSMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Sam A. Overstreet	Present	Present
Vice Speaker	Garnett J. Sweeney	Present	Present
President	Gaithel L. Simpson	Present	Present
President-Elect	David M. Cox	Present	Present
Vice President	Henry B. Asman	Present	Present
Vice President	R. E. Pennington	Present	Present
Vice President	Walter R. Johnson	Present	Present
Secretary	Woodford B. Troutman	Present	Present
Treasurer	Delmas M. Clardy	Present	Present
Delegate to the AMA	Robert C. Long	Present	Present
Delegate to the AMA	J. Vernon Pace	Present	Present
Delegate to the AMA	George P. Archer	Present	Present
Alternate Delegate to the AMA	J. Thomas Giannini	.....	Present
Alternate Delegate to the AMA	John C. Quertermous	Present	Present
Alternate Delegate to the AMA	Carl C. Cooper	Present	Present

TRUSTEES

District			
First	Hugh L. Houston	Present	Present
Second	Howell J. Davis	.....	.....
Third	Ralph D. Lynn	Present	Present
Fourth	Dixie E. Snider	Present	Present
Fifth	Carlisle Morse	Present	Present
Sixth	John P. Glenn	Present	Present
Seventh	Wyatt Norvell	Present	Present
Eighth	Dexter Meyer	Present	Present
Ninth	Mitchel B. Denham	Present	Present
Tenth	Douglas E. Scott	Present	Present
Eleventh	Hubert C. Jones	Present	Present
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Clyde C. Sparks	Present	Present
Fourteenth	William C. Hambley	Present	Present
Fifteenth	Keith P. Smith	Present	Present



The new president of the Kentucky State Medical Association, David M. Cox, M.D., Louisville, elected at the 1962 Annual Meeting of KSMA at Louisville, speaking at the second session of the House, September 19.

PAST PRESIDENTS

Past President	Richard G. Elliott (Deceased)		
Past President	Irvin Abell, Jr.	Present	Present
Past President	R. W. Robertson	Present	Present
Past President	Edward B. Mersch	.....	.....
Past President	Richard R. Slucher	.....	.....
Past President	J. Gant Gaither	.....	.....

DELEGATES

First District

County		First Session	Second Session
BALLARD	Jesse M. Hunt	Present	Present
CALLOWAY	A. D. Butterworth	Present	Present
CARLISLE			
FULTON	R. Ward Bushart	.....	.....
GRAVES	Robert Orr	.....	.....
HICKMAN	V. A. Jackson	.....	.....
LIVINGSTON			
McCRACKEN	George H. Widener	Present	Present
	W. E. Sloan	Present	Present
	Walker Turner	Present	.....
	James H. Harris (Alter.)	.....	Present
MARSHALL	Geo. C. McClain (Alter.)	Present	.....
	William S. Colburn	.....	.....

Second District

DAVIESS	L. P. Moore	Present	Present
	L. C. Dodson	Present	Present
	William Woolfolk	Present	Present
HANCOCK	B. P. Smith	Present	.....
HENDERSON	Kenneth M. Eblen	Present	Present
McLEAN			
OHIO	Oscar Allen	Present	Present
UNION			
WEBSTER			

Third District

CALDWELL	William Jackson	.....	.....
CHRISTIAN	Guinn S. Cost	Present	Present
	Gabe A. Payne, Jr.	Present	Present
CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	Loman C. Trover	Present	Present
	Neal Calhoun (Alter.)	Present	.....
	F. A. Scott	.....	.....
LYON	M. H. Moseley	.....	.....
MUHLENBERG	C. J. Shipp	Present	Present
TODD	J. C. Woodall	Present	Present
TRIGG	Thornton Bryan, Jr.	Present	Present

Fourth District

BRECKINRIDGE	James G. Sills	.....	.....
BULLITT	P. J. Murphy	Present	Present
GRAYSON	A. L. Embry	Present	Present
GREEN	Robert L. Shuffett	Present	Present
HARDIN	Charles F. Long	Present	Present
HART			
LARUE	J. D. Handley	.....	.....
MARION	Salem M. George	Present	Present
MEADE	George E. Clark	.....	.....



New KSMA President David M. Cox, M.D., Louisville, (left) presents the Past President's Key to the retiring president, Gaithel L. Simpson, M.D., Greenville, at the Annual Meeting at Louisville, September 18-20.



KSMA President David M. Cox, M.D., Louisville, (left) talks with the KSMA president-elect, George P. Archer, M.D., Prestonsburg, at the Annual Meeting at Louisville following the election at the second meeting of the House September 19.

NELSON	A. D. Steely	Present	.....
SPENCER	M. H. Skaggs	Present	.....
TAYLOR	H. F. Chambers	Present	Present
WASHINGTON	H. B. Simms (Alter.)	Present	.....
	R. A. Hamilton	.....	Present

Fifth District

JEFFERSON	Charles Bisig	Present	Present
	Austin Bloch	Present	Present
	Harold Eskind	Present	Present
	David Kinnaird	Present	Present
	Paul Mapother	Present	Present
	Harry Pfingst	Present	.....
	George Sehlinger	Present	Present
	David Thurman	Present	Present
	Robert Woodard, Jr.,	Present	Present
	C. Melvin Bernhard	Present	Present
	Ralph M. Denham	Present	Present
	James B. Douglas	Present	Present
	Robert L. McClendon	Present	Present
	William E. Oldham	Present	Present
	B. Frank Radmacher, Jr.	Present	Present
	Henry G. Saam	Present	.....
	Stuart Graves (Alter.)	.....	Present
	George I. Uhde	Present	.....
	Bernard Popham (Alter.)	.....	Present
	T. C. Mitchell (Alter.)	Present	.....
	Wm. Gillespie (Alter.)	.....	Present
	William Vonderhaar	Present	Present
	Charles Bryant	Present	Present
	James Davis	Present	Present
	A. L. Goodman	Present	.....
	Hollis Johnson (Alter.)	Present	.....
	John Hemmer	.....	Present
	Richard Mardis	Present	Present
	Herman Moore	Present	Present
	James Riley	Present	Present
	John Robbins	Present	Present
	Bernard Schoo	Present	.....
	Sam Weakley	Present	Present

Sixth District

ADAIR	George O. Nell	Present	.....
ALLEN	Earl Oliver	Present	Present
BARREN	Eugene L. Marion	Present	Present
BUTLER	John C. Burris	Present	Present
CUMBERLAND	James Beck	.....	.....
EDMONSON	S. E. Farmer	.....	.....
LOGAN	W. R. Byrne	Present	Present
METCALFE	P. D. Hitchcock	.....	.....
MONROE	W. F. Hurt	.....	.....
SIMPSON	L. F. Beasley	Present	Present
WARREN	L. M. Wilson	Present	Present
	Harold Keen	Present	Present

Seventh District

ANDERSON	Boyd Caudill	Present	Present
CARROLL			
FRANKLIN	James Ramsey	Present	Present
GALLATIN			
GRANT	Lenore P. Chipman	Present	Present
HENRY	R. L. Houston	Present	Present
OLDHAM	John H. Leland	Present	.....
OWEN	O. A. Cull	.....	.....
SHELBY	Don Chatham	Present	.....
TRIMBLE	Carl Cooper	Present	Present

Eighth District			
BOONE	Joseph F. Daugherty	.....	.....
CAMPBELL-KENTON	Robert Hoffman	Present	Present
	James J. Kelly	Present	Present
	Donald Janney	Present	Present
	Thomas McElhinney	Present	Present
	Richard Allnutt	Present	Present
	Paul Klingenberg	Present	Present
Ninth District			
BATH			
BOURBON			
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	R. W. Fidler	.....	.....
HARRISON	H. H. Moody	Present	.....
MASON	William Cartmell	Present	Present
NICHOLAS	W. R. Kingsolver	.....	.....
PENDLETON	William N. Townsend	.....	.....
ROBERTSON			
SCOTT	R. G. Wheeler	Present	.....
Tenth District			
FAYETTE	Carl H. Fortune	Present	Present
	Maurice Kaufmann	Present	Present
	Robert D. Shepard	Present	Present
	Harvey Chenault	Present	Present
	N. L. Bosworth	Present	Present
	M. R. Gilliam	Present	Present
	L. E. Hurt	Present	Present
	E. D. Pellegrino	Present	Present
	J. H. Saunders	Present	Present
	E. C. Strode	Present	Present
JESSAMINE	J. S. Williams	Present	.....
WOODFORD	Olsen Parrott	.....	Present
Eleventh District			
CLARK	Eugene Snowden	.....	.....
ESTILL	Omar C. Amstutz	.....	.....
JACKSON			
LEE	E. J. Broaddus	.....	.....
MADISON	Eugene Bowling	Present	Present
	Max E. Elue (Alter.)	Present	Present
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	Caleb H. Y. Chu	.....	.....
POWELL	S. T. Scrivner	Present	.....
WOLFE	Paul F. Maddox	.....	.....
Twelfth District			
BOYLE	Chris S. Jackson	Present	Present
CASEY			
CLINTON	Ernest A. Barnes	.....	.....
GARRARD	O. S. Playforth	Present	Present
LINCOLN	H. I. Frisbie	Present	Present
McCREARY	M. A. Winchester	.....	.....
MERCER	John S. Baughman	.....	.....
PULASKI	A. L. Cooper (Alter.)	Present	.....
	C. R. Faulkner	Present	Present
	B. L. Ramsey	.....	.....
ROCKCASTLE	J. D. Lewis	Present	.....
RUSSELL	James E. Monin	Present	Present
WAYNE	John W. Simmons	Present	Present
Thirteenth District			
BOYD	Guy C. Cunningham	Present	Present
	Walter Cawood	Present	Present
CARTER	J. Watts Stovall	Present	Present
ELLIOTT	John F. Greene	.....	.....
GREENUP	C. B. Johnson	Present	.....
LAWRENCE	William J. McNabb	.....	.....
LEWIS			
MORGAN	R. L. Gullett	.....	.....
ROWAN			
Fourteenth District			
BREATHITT	Price Sewell, Jr.	.....	.....
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	D. G. Barker	.....	Present
LETCHER	T. M. Perry	Present	Present
MAGOFFIN			
MARTIN			
PERRY	Cordell H. Williams	Present	.....
PIKE	Ballard Cassady (Alter.)	Present	Present
Fifteenth District			
BELL	Charles Stacy	Present	Present
CLAY	W. E. Becknell	Present	.....
HARLAN	E. M. Howard	Present	Present
	David M. Greeley	Present	Present
KNOX	F. X. Sommer	Present	.....
LAUREL	E. C. Seeley	Present	Present
LESLIE			
WHITLEY	Harold Barton	Present	Present

**The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings on September 17 and 19.*

B. C. Bach, M.D., Honored

B. C. Bach, M.D., 80, Whitesburg, Ky., one of Kentucky's oldest general practitioners, was named Whitesburg "Man of the Year" September 5 and honored at a dinner of the Whitesburg Lions Club which makes the award annually. Doctor Bach, a native of Breathitt County, is the last survivor of four brothers, all of whom were physicians. Wilgus Back, M.D., Jackson, died in 1936; Arthur Bach, M.D., Lexington, in 1952 and Luther Bach, M.D., Florence, in 1953.



Pictured during the featured "standing-room-only" Transatlantic CPC Conference at the KSMA Annual Meeting, September 19, are, left to right, members of the Kentucky panel, all of the Medical Center, Lexington: Harold D. Rosenbaum, M.D.; E. D. Pellegrino, M.D., moderator; Frank Cole Spencer, M.D., and Wellington B. Stewart, M.D. Above the Kentucky panel are pictures of the Glasgow, Scotland, physicians who participated in the transatlantic telephone hook-up discussion. As each of the British panelists spoke a red light at the top of his picture went on to indicate who was speaking.

COMPARATIVE REGISTRATION FIGURES

KSMA Annual Meetings

	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962
KSMA Members	786	924	938	923	1094	971	997	1021	996	1014
Guest Physicians	75	150	122	157	178	166	165	203	194	208
Interns-Residents	100	148	106	105	142	108	128	105	102	102
Medical Students	292	284	299	305	328	269	280	289	237	176
Registered Nurses	31	25	55	15	28	22	34	25	31	59
Exhibitors	153	174	174	218	176	211	200	239	204	232
Guests	72	166	121	108	151	164	86	99	132	123
Technicians—										
Office Assistants	54	67	50	54	54	45	63	33	57	71
TOTAL ATTENDANCE	1563	1938	1865	1885	2151	1956	1953	2014	1953	1985

Physicians Appear On TV and Radio During KSMA Meet

F. J. L. Blasingame, M.D., Chicago, executive vice president of the American Medical Association, appeared on television in Louisville, during the Annual Meeting of the Kentucky State Medical Association, as did other physicians attending the session, September 18-20 at Louisville.

Doctor Blasingame appeared on the "Morning Show" on WAVE-TV.

E. Stanley Crawford, M.D., Houston, Tex., associate professor of surgery, Baylor University College of Medicine, was a guest on "Small Talk" on WHAS-TV.

Others who made radio talks were: O. B. Murphy, M.D., Lexington, WKYW; William T. Rumage, M.D., Louisville, WHAS; Gaithel L. Simpson, M.D., Greenville, immediate past president of KSMA, who taped a talk on conservation, to be sent to radio stations throughout the state.

Mrs. Kinsman Is President-Elect

Mrs. J. Murray Kinsman, Louisville, was named president-elect of the Woman's Auxiliary to the Kentucky State Medical Association at its annual convention in Louisville, September 18-20.

Mrs. James Sears Rich was installed as new president during the session. The meeting was held in conjunction with the Annual Meeting of KSMA. Other new officers: Mrs. Paul F. Rizk, Grayson, first vice president; Mrs. J. Jack Martin, Tompkinsville, second vice president; Mrs. Ballard Cassady, Pikeville, third vice president; Mrs. Charles Kissinger, Henderson, fourth vice president; Mrs. Robert J. Salisbury, Mt. Sterling, recording secretary; Mrs. J. Andrew Bowen, Louisville, corresponding secretary; Mrs. Graydon Long, Lexington, treasurer; Mrs. Carlisle Morse, Louisville, parliamentarian; Mrs. Marvin A. Lucas, Louisville, editor, Blue Grass News; Mrs. Earl W. Roles, Prospect, co-editor; Mrs. Robert B. Nolan, Louisville, convention chairman; Mrs. Edward J. Fadell, Louisville, co-chairman; Mrs. Charles Stacy, Pineville, publicity chairman.

KSMA Championship Golf Trophy Won by Doctor Scalzitti

C. J. Scalzitti, M.D., Louisville was winner of the KSMA Championship trophy at the annual KSMGA Golf Tourney during the Annual Meeting of the Kentucky State Medical Association at Louisville, September 18-20.

Harold W. Baker, M.D., Louisville, was chairman of the golf committee for the 1962 Annual Meeting. The tournament was held at Wildwood Country Club.

Doctor Baker announced the winners, who also included: Low Net Trophy, Darl B. Shipp, M.D., Dry Ridge, Ky.; Senior Championship Trophy, Thomas J. Overstreet, M.D., Lexington, winner for the fifth consecutive year.

Daily low net and low gross winners: September 18 and 19 Low Gross—Eugene Snowden, M.D., Winchester, Ky.; September 18 and 19 Low Net—Harold Moberly, M.D. Winchester, Ky.; September 20 Low Gross—Glenn W. Bryant, M.D., Louisville, and September 20 Low Net—Ben C. Stigall, M.D., Owensboro, Ky.

Nominating Committee Named

The House of Delegates elected the five-member Nominating Committee — to nominate general officers for the 1963 Annual Meeting of the Kentucky State Medical Association which will be held at Lexington—at the 1962 Annual Meeting September 18-20. Members are as follows: Ballard Cassidy, M.D., Pikeville; James B. Douglas, M.D., Louisville; Carl Fortune, M.D., Lexington; Gabe A. Payne, M.D., Hopkinsville; Loman C. Trover, M.D., Madisonville. A chairman will be elected at the interim meeting.

Christian on Committee

Joe C. Christian, 1961-62 president of the University of Kentucky Chapter of the Student American Medical Association, was a member of the SAMA Reference Committee on Medical Education for the 1962 meeting of that Association. A picture of the Committee appears in the October issue of The New Physician, SAMA Journal.



LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)

ANTIDIARRHEAL TABLETS and LIQUID

lowers motility / relieves cramping / controls diarrhea

Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

Visiting Physicians Praise KSMA Annual Meeting

"Thank you for your letter of September 25, 1962, containing the resolution of the House of Delegates of the Kentucky State Medical Association. I was honored to be asked to participate in your annual meeting and feel that I gained much from this opportunity and also from the acquaintances I was able to make from your members.

"I also wish to again express my appreciation for the many kindnesses extended by you and your staff to me and your excellent cooperation in making my trip such a pleasant one."

Ray T. Parmley, M.D., director, Department of Anesthesiology, St. Francis Hospital, Wichita, Kan.

"I enjoyed my visit to Louisville immensely and only wish I could have seen more of you."

James A. Halsted, M.D., chief, Department of Medicine, Metropolitan Hospital, Detroit.

"I wish to thank you for the pleasant time I had during my participation in the State Medical Association Meeting last week."

Gerard B. Odell, M.D., professor of pediatrics, Medical College of Virginia, Richmond.

"I appreciate very much the opportunity of participating in the scientific program and was impressed with the many fine physicians from the State of Kentucky. I particularly appreciated the nice plate of fruit that was waiting for me at the hotel when I arrived Monday afternoon.

"There were many good scientific sessions and I made a special effort to attend those in addition to the numerous events in which I participated during the several days' session."

R. Drew Miller, M.D., associate director, Mayo Foundation for Medical Education and Research, University of Minnesota Graduate School, Rochester.

"I want to thank you for the many courtesies extended to me during my participation at the medical society meeting."

E. Stanley Crawford, M.D., Baylor University College of Medicine, Houston, Tex.

"The hospitality extended to me by members of the Association and particularly by Edward Maxwell, M.D., was very much appreciated. This made my trip a most pleasant one."

William R. Eyler, M.D., chairman, department of radiology, Henry Ford Hospital, Detroit.

"On behalf of myself and the Kentucky Pharmaceutical Association, I wish to thank you and your association for the invitation extended to me to attend the recent Annual Meeting of the Kentucky State Medical Association.

"I thoroughly enjoyed the President's Luncheon held Wednesday, September 19. The remarks by F. J. L. Blasingame, M.D., were inspiring and the awards by William Bizot, M.D., were heart-warming.

"After the luncheon, I attended the Transatlantic CPC between the panel of Lexington, Ky., physicians and a team of physicians from Glasgow, Scotland. I had heard of this type program but never had the occasion to witness it. It was really outstanding and informative in all respects.

"Then I proceeded to visit the many professional exhibits, which were very well organized and offered much up-to-date information pertaining to the most modern and useful medicinals in the medical world. I met physicians and many of the medical service representatives, whom I know through my daily activities.

"I hope that representatives of the allied professions continue to meet at frequent intervals to maintain a strong link in all their undertakings.

"Thanks again for the courtesy and hospitality shown me."

Coleman Friedman, R.Ph., first vice president, Kentucky Pharmaceutical Association.

"I need not tell you that my trip to Kentucky was a highly pleasant and successful one from my point of view, and I am writing to thank you for all your help and kindness. I particularly appreciated the bowl of fruit which was waiting for me on my arrival in my hotel room.

"Again, many thanks for making my trip such a pleasant experience."

John C. Nemiah, M.D., psychiatrist, Massachusetts General Hospital, Boston.

"I hope you will convey to Doctor Simpson, your immediate past president, and to Doctor Cox, your new president, our thanks for the gracious reception and treatment my wife and I received as guests of your society in Louisville, Kentucky, last week. I thought it was an excellent meeting.

"My wife certainly appreciated the fruit delivered to our room and enjoyed attending the Auxiliary session that day. I thoroughly enjoyed the noon luncheon and thought the International Panel, at 2 p.m. was wonderful. However, I was most interested in sitting through the meeting of your House of Delegates that evening. You are doing a great work and I think the doctors of Kentucky really enjoy this work and take it seriously. They are to be complimented.

"We are looking forward to our annual meeting—starting May 12—and I hope you and Doctor Cox can be our guests in Cleveland."

Horatio T. Pease, M.D., president-elect, Ohio State Medical Association, Wadsworth, Ohio.

"Thanks for the many courtesies extended to me during my recent, brief visit to the Kentucky State Medical Association Annual Meeting. I was honored to participate on the program; and I trust that Doctor Simpson, other members of the Association, and you and your staff were satisfied with the result."

F. J. L. Blasingame, M.D., executive vice president, American Medical Association, Chicago.

"It was a pleasure to have participated in the meeting last week. The fine hospitality extended to me by members of your Association was much appreciated.

"When I arrived in my room in the hotel, the first

thing that caught my eye was the complimentary bowl of fruit. I enjoyed this and thank you."

May Roy Gasque, M.D., corporate medical director, Olin Mathieson Chemical Corporation, New York City.

"It was a pleasure to attend the sessions of the Association, and I trust that my contributions were satisfactory. I regret that my plans were such that I was unable to attend the President's Luncheon. Thank you very much for the provisions made for my stay."

Edward A. Gall, M.D., director, department of pathology, University of Cincinnati College of Medicine, Cincinnati.

"It was a pleasure to have attended your Association meeting."

Harold M. Childress, M.D., Jamestown, N. Y.

"Thank you very much for your cordial welcome and for the comfortable accommodations which were arranged for me during my two-day stay in Louisville as a guest of the Kentucky State Medical Association."

J. Leonard Goldner, M.D., professor of orthopaedic surgery, Duke University Medical Center, Durham, N. C.

11 Ky. Surgeons Named to College

The American College of Surgeons meeting at Atlantic City, N.J., October 18 initiated new fellows into its group, including 10 Kentuckians: Wilford L. Cooper, M.D., Lexington; Charles J. Bisig, M.D.; J. Alex Haller, Jr., M.D.; Peggy J. Howard, M.D.; Alvin Lebendiger, M.D.; Roderick Macdonald, Jr., M.D.; William M. Moses, M.D., and John P. Stamer, Jr., M.D.—all of Louisville; Joseph R. Bolton, M.D., Paris, and Robert B. Jasper, M.D., Somerset.

Major Harry B. Ditmore, Jr., Ft. Knox, was also initiated into the College.

AMA Membership Dues $45 in '63

At the New York Annual Meeting of the American Medical Association in June 1961, the House of Delegates approved the following increase in AMA Membership dues—January 1, 1962-$35 (for the 1962 calendar year); January 1, 1963-$45 (for the 1963 calendar year.)

U. of L. Makes Appointment

Philip J. Maloney, M.D., and Thomas S. Wallace, Jr., M.D., have been named instructors in community health at the University of Louisville School of Medicine. Cecil L. Grumbles, M.D., has been named instructor in obstetrics and gynecology; Cavit Ozlu, M.D., instructor in pathology, and John Apley, M.D., visiting professor of pediatrics.

John W. Brown, Ph.D. assistant professor of biochemistry, has been named associate director of the Commonwealth Fund curriculum study now going on at the School. Promoted are: Eugene E. Woodside, M.D., from assistant to instructor in microbiology and Lawrence A. Davis, from associate professor to professor of radiology.

U. of L. Hosts Aviation Seminar

Some 70 out-of-state physicians attended the three-day seminar for aviation medical examiners at Louisville, October 3-5. Banquet speaker was Richard L. Meiling, M.D., dean of the Ohio State University School of Medicine. Some 28 members of the faculty of the U. of L. School of Medicine served as lecturers, panelists and panel moderators along with others from outside Kentucky.

The Louisville seminar was attended by physicians from the New England States, Ohio, Virginia, West Virginia and Kentucky. In charge of arrangements were: Hobart L. Belknap, M.D. lecturer in medical care; Arthur H. Keeney, M.D., assistant professor of ophthalmology; Frank M. Gaines, Jr., M.D., assistant professor of psychiatry—all of the U. of L.

Ky. Thoracic Society Meets

A panel discussion on "Histoplasmosis in Central Kentucky" was featured at the scientific meeting of the Kentucky Thoracic Society September 27 at the University of Kentucky Medical Center, Lexington. Nathan Levene, M.D., president of the Society, presided, and Walter Herrell, M.D., was moderator of the panel, which included: I. Zapolsky, M.D., and A. Balows, M.D., along with Richard Crutcher, M.D.; Earle Spencer, M.D., and William Grayboski, M.D., all of Lexington. Michael Furcolo, M.D., Kansas City, Mo., led the discussion. The meeting was attended by 70 physicians.

The Society is planning another meeting at Jenny Wiley State Park November 15. Medical specialists from Louisville and Ashland are scheduled to address the session which begins at 2 p.m.

Edwin Paul Scott, M.D., and **D. Geraldine Paxton, M.D.,** have announced their association for the practice of pediatrics at Louisville. Doctor Scott was graduated from the University of Louisville School of Medicine in 1940 and Doctor Paxton, in 1953.

Edwin H. West, M.D., has entered private practice at Olive Hill, Ky. He was formerly director of local health for the Kentucky State Department of Health, Frankfort. Dr. West is a 1937 graduate of Tulane University School of Medicine. He joined the Department of Health in 1958 and was director of local health for four years, in which position he is succeeded by **Edward M. Thompson, M.D.,** who has been named acting director.

William Peter Linss, M.D., Newport, has been named by the Newport Board of Health to be city health administrator, succeeding **Elmer Richard Schnake, M.D.,** who died August 12. Doctor Linss is a graduate of Tulane University School of Medicine.

James E. Johnson, Jr., M.D., has started general practice at Millersburg, Ky. He was graduated from the University of Tennessee Medical School in 1959 and interned at Roanoke Memorial Hospital, Roanoke, Va. Doctor Johnson served for two years as a captain in the U. S. Army. He previously practiced at Madisonville, Ky.

Survey Shows Payroll Taxes For Care of Aged Unjust, Says Fister

A new survey of the economic condition of American families, made by the University of Michigan Survey Research Center, proves again the injustice of forcing higher payroll taxes on the nation's workers to buy health care for the aged, according to George M. Fister, M.D., president of the American Medical Association.

"Analysis of the survey findings once again demonstrates, as other studies have, that the aged as a group are substantially better off on the average than younger Americans," Doctor Fister said.

"It must be concluded that the push for federalized health care for the aged is not just a simple fraud, but what's worse, it's a fraud being perpetrated for political purposes," he said, and added: "The aged are being exploited for political power and the taxpayers are being hoodwinked for the same purpose."

The survey shows, among other things, according to Doctor Fister, that: The median value of total assets owned by families with the head of the family over age 65 was $8,349 in 1960, almost twice as much as the $4,839 which was the median value of total assets of all other age groups as determined by the study. (The term family is substituted for "spending unit," the basis of the study, for greater clarity.)

It also shows that the median value of equity in a home for the over-65 families was $4,559, almost four and one-half times as much as the $1,028 reported for younger families; that 63% of over-65 families own assets valued at $5,000 or more compared with 47% of younger families.

Forty-one per cent of the aged hold assets valued at $10,000 or more, according to the survey, said Doctor Fister, compared with 27% of younger groups; while 18% have assets of $25,000 or more, contrasted with only nine per cent of younger families.

Among aged families, 74% had no personal debt, compared with 34% of younger families and 86% reported no installment debt, compared with 48% of all other age groups, the Doctor said.

In an evaluation of the survey given to the press October 25, the University of Michigan indicated that their interpretation of statistics showed older people were worse off financially than younger age groups. No comment was made on the AMA statement.

State Now Using Outwood Hospital

The old Outwood Springs Veterans Hospital, Dawson Springs, Ky., has been opened as Kentucky's second center for mentally retarded children, according to Harold L. McPheeters, M.D., state mental health commissioner. Marvin Logsdon, business supervisor, Western State Hospital, Hopkinsville, has been named acting superintendent of the hospital which will be formally turned over to the State in about two months. In a year, Doctor McPheeters said, the hospital, will have a staff of 150 to 200 and about 500 patients.

Social Security System Continues In Red, Says AMA Council

The U. S. Treasury Department's preliminary figures for the fiscal year ended June 30, 1962, shows that the Social Security system lost $1,248,000,000 according to the American Medical Association's Council on Legislative Activities.

OASI receipts reached a new high of $12,022,000,000 but rapidly rising expenditures rose to $13,270,000,000, according to the Council. News sources, the Council said, indicate that the Treasury Department does not expect to get the system into the black next year but estimates receipts at $14,120,000,000 and expenditures at $14,171,000,000.

The Council points out that despite increases in tax rates and in the tax base in recent years, Social Security lost money in 1957, 1958 and 1959, and adds that critics of the Social Security approach to health care of the aged have said repeatedly that the addition of a health care program with its unpredictable costs would jeopardize the entire Social Security structure.

Two Join V.A. Hospital Staff

Henry Tesluk, M.D., and Richard Bryant, M.D., have been added to the staff of the Veterans Administration Hospital, Lexington.

Doctor Tesluk will be acting chief of the Hospital Laboratory Service. He is associate professor in the Department of Pathology at the U. of K. Medical Center and is a graduate of Cornell University School of Medicine. Doctor Bryant is an instructor on the U. of K. Medical College's dean's committee. He is a graduate of the University of Cincinnati Medical School. In January 1962 the V.A. Hospital opened a 100-bed medical and surgical ward and the U. of K. has assigned residents and interns to the hospital for training and instruction.

TB Educational Campaign Planned

A nationwide educational campaign to alert people to recognize two symptoms of chronic respiratory disease is planned by the National Tuberculosis Association for May through June 15, 1963. Two questions: "Cough too much?" and "Short of breath?" will be asked and those answering affirmatively will be urged to consult their physicians about these symptoms.

The National Association will be joined by its affiliated local groups in the campaign and these will seek the advice and cooperation of local medical societies in promoting the campaign in their localities.

New KSMA Members Reported

New members of the Kentucky State Medical Association, all of Bowling Green, are as follows: William B. Russell, M.D.; William Rowlett, M.D.; Henry Meiers, M.D.; Thomas Kirby, M.D., and Roy Slezak, M.D.

Robert M. Sigler, M.D., Albany, Ky., has gone to the Mayo Clinic, Rochester, Minn., for further study in surgery. He has been associated wtih **Floyd B. Hay, M.D.**, at the Maple Hill Hospital for two years.



Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

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Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
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Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

U. of K. Surgery Program

The Department of Surgery of the University of Kentucky College of Medicine will present the following program the third Thursday of each month during the academic year, beginning November 15. It will be designated "Monthly University Surgical Day."

Beginning at 8 a.m. there will be orientation as to the day's program; 8:30 to 10 a.m., ward rounds with Ben Eiseman, M.D., chairman, Department of Surgery; 10:30 a.m. to 12 noon, observation in operating rooms of cases presented in ward rounds; 1:15 to 3 p.m., problem case clinic: presentation of problem cases with a discussion panel from other departments — physicians attending are urged to bring their own problem cases before the panel; 3:15 to 4:30 p.m., seminar on a single current subject.

Community Medicine Course

William H. Anderson, M.D., Harlan, will present the second lecture in the Postgraduate Grand Rounds series, sponsored by the Department of Community Medicine, University of Kentucky Medical Center, Lexington.

Doctor Anderson's lecture will be presented from 4 to 5:30 p.m., November 30, at the Center. The third lecture, "Management of the Unhospitalized Tuberculosis Patient," will be presented December 21, from 4 to 6 p.m., at the Center, by Aaron Chaves, M.D., supervisor of clinics, Bureau of Tuberculosis, New York City Department of Health. Mark T. Hoegenga, M.D., Wm. S. Merrell Co., Cincinnati, made the first presentation October 26.

In Kentucky

NOVEMBER

14-21-28	"Electrocardiogram Interpretation," 7 to 9 p.m., Thursday evenings, Louisville General Hospital, Louisville, Ky.
15	"X-Ray Diagnosis of Chest Diseases," 7:30 p.m. University of Kentucky Medical Center, Lexington, Ky.
30	Postgraduate Grand Rounds, Department of Community Medicine, University of Kentucky Medical Center, 4-5:30 p.m., Lexington, Ky.

DECEMBER

5-12-19	"Electrocardiogram Interpretation," 7 to 9 p.m., Thursday evenings, Louisville General Hospital, Louisville, Ky.
13	Fifth Annual Postgraduate Medical Seminar, Norton Memorial Infirmary, Louisville, Ky.
21	Postgraduate Grand Rounds, Department of Community Medicine, University of Kentucky Medical Center, 4-6 p.m., Lexington, Ky.

JANUARY

2-9-16	"Electrocardiogram Interpretation," 7 to 9 p.m., Thursday evenings, Louisville General Hospital, Louisville, Ky.
11	Kentucky Radiological Society, Sheraton Hotel, Louisville, Ky.
24	KAGP Northern Kentucky Seminar, Sheraton Gibson Hotel, Cincinnati, Ohio.

Surrounding States

NOVEMBER

25-28	AMA Clinical Meeting, Los Angeles, Calif.

JANUARY

9-10	"Advances in Internal Medicine," Indiana University Medical Center, Indianapolis, Ind.
28-Feb. 1	Clinical III Diagnostic Use of Radio Isotopes, Oak Ridge Institute of Nuclear Studies, Medical Division, Oak Ridge, Tenn.

News Of The Profession In and About Kentucky

Adrian N. Collins, M.D., has entered general practice in association with **B. J. Riddle, M.D.,** at South Shore, Ky. Doctor Collins was graduated from the University of Louisville School of Medicine in 1961 and interned at St. Rita's Hospital, Lima, Ohio.

John A. Logan III, M.D., has started general practice at Sebree, Ky. Doctor Logan was graduated from Vanderbilt University Medical School in 1961 and interned at the Toledo, Ohio, Hospital. He previously practiced at Toledo.

Henry N. Meiers, Jr., M.D., has started the practice of general surgery at Bowling Green, Ky., in association with the Graves-Gilbert Clinic. Doctor Meiers was graduated from the Vanderbilt University Medical School in 1955 and interned at Barnes Hospital, St. Louis, Mo. He served in the U. S. Army as a captain for two years and took residency training at Barnes Hospital following his Army service.

George W. Wayman, M.D., has joined the Somerset Clinic, Somerset, Ky., for the practice of obstetrics and gynecology. Doctor Wayman was graduated from the University of Cincinnati Medical School in 1954. He served his internship at Walter Reed Hospital and hs residency at the Tripler Army Hospital in Honolulu. Doctor Wayman was with the U. S. Air Force as a pilot from 1942 to 1945 and served with the Army in a medical capacity from 1954 to 1962.

Robert G. Townsend, Jr., M.D., has begun general practice at Grayson, Ky., in partnership with **J. Watts Stovall, M.D.** Doctor Townsend received his M.D. degree from the University of Louisville in 1961. He interned at Marion County General Hospital, Indianapolis.

Sydney G. Dyer, M.D., has started general practice at LaCenter, Ky. Doctor Dyer was graduated from the University of Louisville School of Medicine in 1942 and interned at California Hospital, Los Angeles. He served as a lieutenant colonel in the Medical Corps of the U. S. Army from 1943 to 1946 and from 1961 to 1962. He is a member of the 439th Civil Affairs Company, Paducah, Ky., which was called to active duty during the Berlin crisis. He previously practiced at LaCenter.

William R. Jernigan, M.D., is practicing general surgery in association with the Trover Clinic, Madisonville, Ky. Doctor Jernigan was graduated from the University of Tennessee College of Medicine, Memphis, in 1955 and interned at Protestant Deaconess Hospital, Evansville, Ind. He was a resident at Kennedy V. A. Hospital for four years and was previously in general practice for two years.

Jacob D. Farris, M.D., Lexington, Ky., physician with the University of Kentucky Health Service, retires in September. He has been with the University since 1948. Before that he was with Eastern Kentucky State College at Richmond and at Emory University in Georgia.

Alfred A. Jacobs, M.D., has opened an office for the practice of obstetrics and gynecology at South Fort Mitchell, Ky. Doctor Jacobs was graduated from the University of Louisville School of Medicine in 1957. He served his internship at St. Elizabeth Hospital, Covington, and his residency at Louisville General Hospital in obstetrics and gynecology, and at Good Samaritan Hospital, Cincinnati, in general surgery.

Francis H. Bledsoe, M.D., has entered the practice of internal medicine and renal diseases at Lexington, Ky. He is practicing in association with the University of Kentucky Medical Center. Doctor Bledsoe was graduated from the Medical College of South Carolina at Charleston in 1953. He interned at the District of Columbia General Hospital and was a resident at the Mayo Foundation. Doctor Bledsoe also held clinical and research fellowships at Georgetown University Medical Center, Washington, D. C., and served as a captain in the Medical Corps of the U. S. Air Force for two years.

Behdan Cymbala, M.D., is serving in the pathology departments of Methodist Hospital, Henderson, and Our Lady of Mercy Hospital, Owensboro. Doctor Cymbala was graduated from medical school at Liege, Belgium, in 1949 and interned at a Paterson, N. J., hospital. He served his residency in pathology at Pueblo, Colo., and at the U. S. Naval Hospital at Oakland, Calif. He served as a lieutenant commander in the Navy from 1955 until 1958 and previously practiced at Evansville, Ind.

Carlos de Armendi, M.D., has entered general practice in association with the Methodist Hospital, Pikeville, Ky. Doctor de Armendi is a 1945 graduate of the Havana, Cuba, School of Medicine. He interned and was a resident at the San Juan Clinic and was one of 10 doctors who owned that clinic. Previously he was in private practice at Jaruco City, Cuba.

Robert H. Wilber, M.D., has opened an office for general practice at Lebanon, Ky. Doctor Wilber was graduated from the University of Louisville School of Medicine in 1958 and interned at St. Anthony Hospital, Louisville. He served for two years as a captain in the U. S. Air Force and was previously in practice at Jeffersonville, Ind.

Robert K. Dorton, M.D., who was graduated from the Vanderbilt University School of Medicine in 1959, has started general practice at Louisa, Ky. Doctor Dorton interned at Ohio State University Hospital. He served for two years in the U. S. Public Health Service as a surgeon. He is practicing in association with **Hobart Lester, M.D.**

Justin MacCarthy, M.D., has joined the Howard Clinic at Glasgow, Ky. He will practice general surgery. Doctor MacCarthy was graduated from the National University of Ireland in 1955. He interned at General Hospital, St. Johns, Newfoundland, and did residency work at St. Joseph Infirmary, Louisville.

In Memoriam

FRANK HAYS THRELKEL, M.D.
Owensboro
1910-1962

Frank Hays Threlkel, 52, Owensboro, Ky., pediatrician and anesthesiologist, died October 1 at Owensboro-Daviess Hospital after a three-months' illness. Doctor Threlkel was a graduate of the United States Naval Academy at Annapolis and was graduated from the University of Louisville School of Medicine in 1935. He began practicing at Owensboro in 1946; was a past president of the Daviess County Medical Society.

MARVIN SPEED VEAL, M.D.
Madisonville, Ky.
1878-1962

Marvin Speed Veal, 84, Madisonville, Ky., retired general practitioner, died September 14 at Kentucky Rest Haven, Madisonville, where he had been a patient since 1959.

Doctor Veal was graduated from the Hospital College of Medicine, Louisville, in 1906 and practiced at Daniel Boone, Ky., before moving to Madisonville. He served with the U. S. Army Medical Corps in the Philippines during the Spanish-American War and also during World War I.

JAMES GARFIELD GLASS, M.D.
Henderson, Ky.
1882-1962

James Garfield Glass, M.D., 79, Henderson, Ky., retired general practitioner, died September 7 at his home at Henderson after a long illness. He practiced medicine at Henderson for 50 years before he was stricken with illness in July 1959.

Doctor Glass was city physician at Henderson for 35 years. He was graduated from Meharry Medical College, Nashville, Tenn., in 1908. A special day in his honor was observed in December 1959 when tribute was paid to him for his "public service."

JOE E. LANE, M.D.
Lexington
1917-1962

Joe E. Lane, M.D., 45, Lexington, Ky., proctologist died unexpectedly September 30 at his home at Lexington. Doctor Lane was a 1951 graduate of the University of Louisville School of Medicine.

TROILUS MELCOY RADCLIFFE, M.D.
Smithland
1875-1962

Troilus Melcoy Radcliffe, 86, Smithland, Ky., general practitioner for 56 years, died at his home September 30. Doctor Radcliffe was a 1904 graduate of the Medical Department of the University of Louisville. He was at Smithland except from 1928 to 1930 when he practiced at Whitesburg. Some years ago he was honored for his service to his community.





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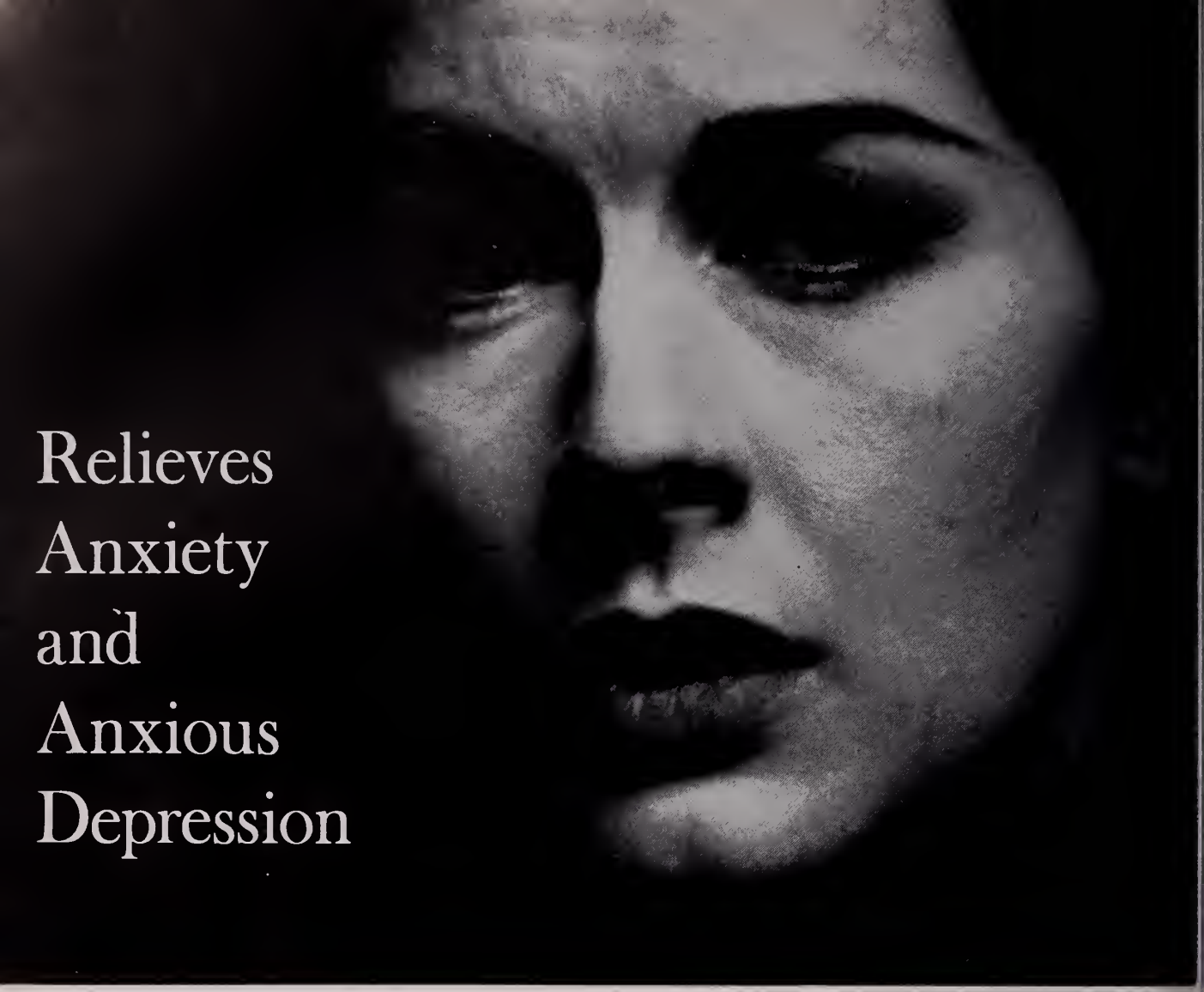
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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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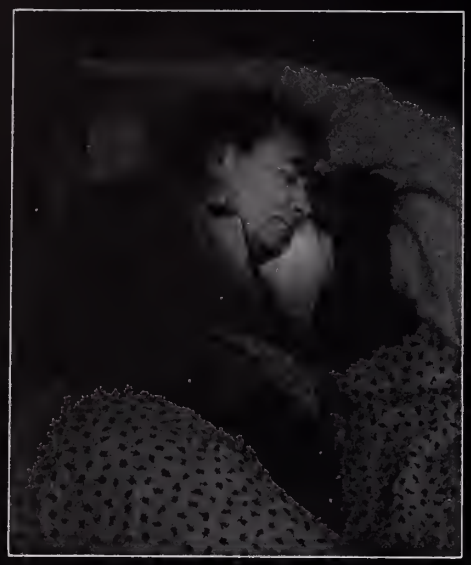
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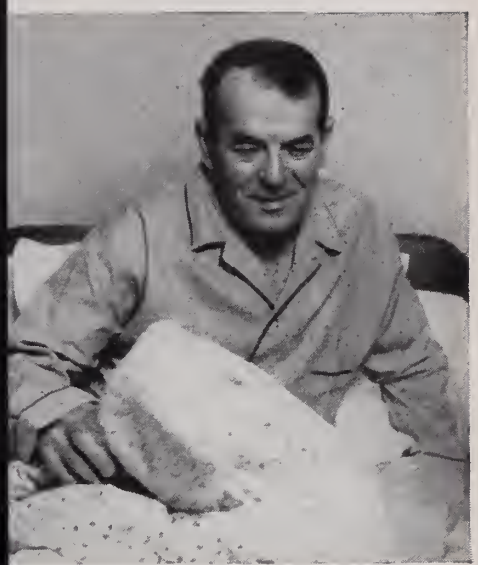
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NEWS ITEMS

Paul R. Kleykamp, M.D., Ashland, Ky., has been named to the Ashland Board of Education.

Edward Haick, M.D., has opened an office at Louisville for general practice. Doctor Haick was graduated from the University of Louisville School of Medicine in 1961 and interned at St. Joseph Infirmary.

James G. Pope, M.D., has become associated with **Claude W. Trapp, Jr., M.D.**, at Lexington, Ky., in the practice of ophthalmology. Doctor Pope was graduated from the University of Louisville School of Medicine in 1955. He interned at Philadelphia General Hospital and did his residency work at Henry Ford Hospital, Detroit, Mich. Doctor Pope served for two years as a captain in the U. S. Air Force.

James Arthur Orr, Jr., M.D., has begun the practice of internal medicine in association with the Lexington Clinic, Lexington, Ky. Doctor Orr received his M.D. degree from the University of Louisville in 1955. He interned and did his residency work at Henry Ford Hospital, Detroit, Mich. He served two years with the U. S. Air Force with the rank of captain.

Lean Bowman, M.D., formerly in general practice at McKee, Ky., has started practice at Flemingsburg, Ky. He was at McKee for two years and is a graduate of the University of Louisville School of Medicine.

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1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

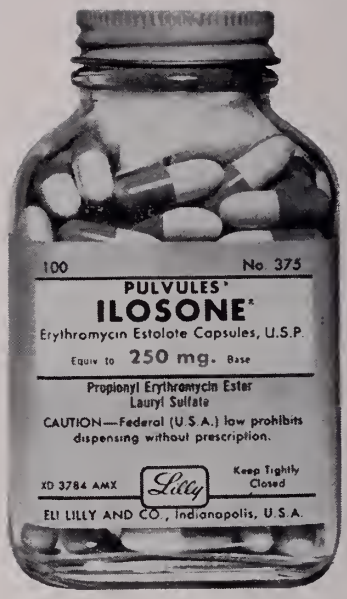
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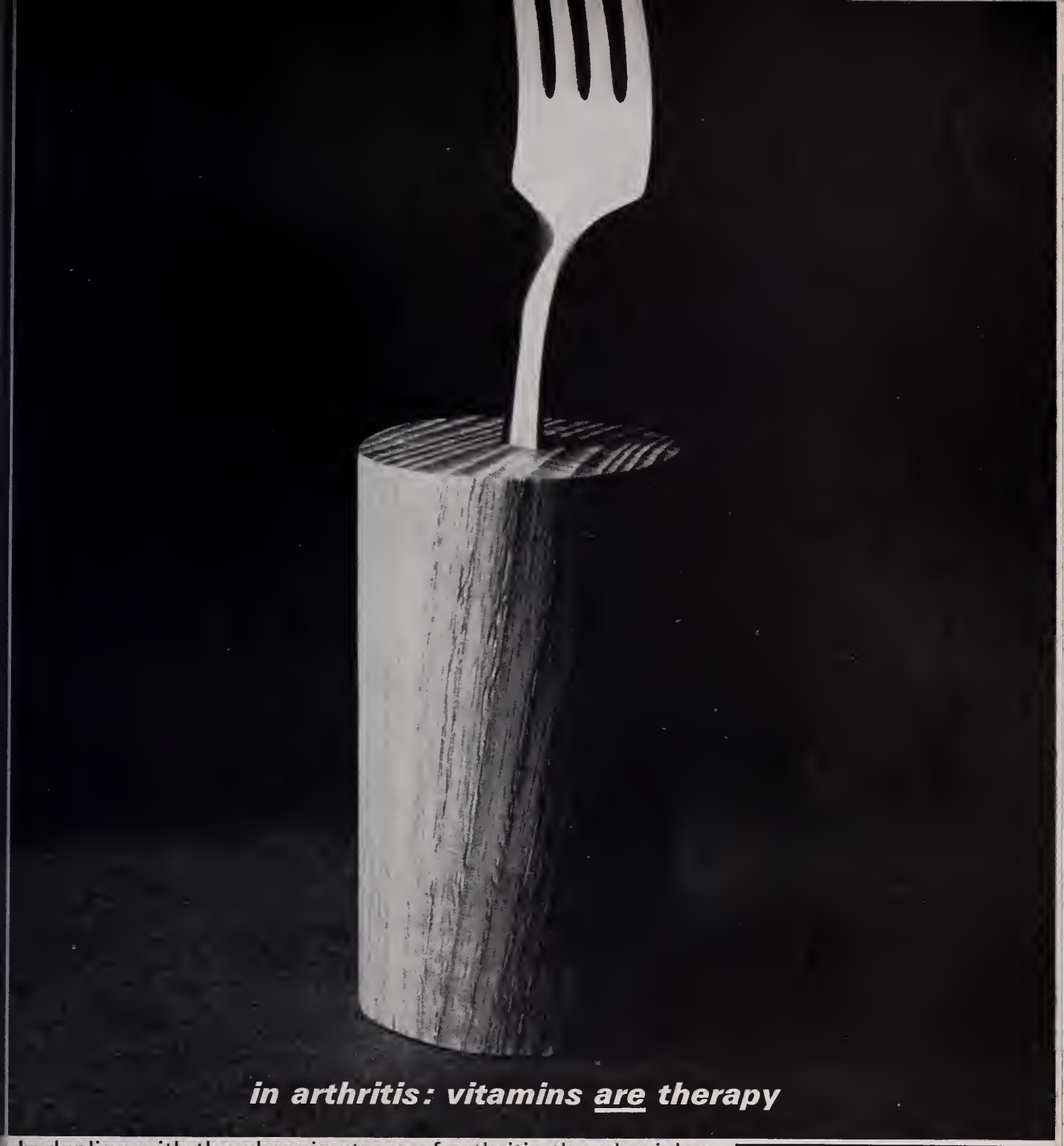
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IN THE BOOKS

THORACIC DISEASES: EMPHASIZING CARDIOPULMONARY RELATIONSHIPS; by Eli H. Rubin, M.D., and Morris Rubin, M.D., in association with George C. Leiner, M.D., and Doris J. W. Eschler, M.D.; published by W. B. Saunders Co., Philadelphia; 968 pages; price $25.

Since 1947, the year in which Eli Rubin, M.D., published his ""*Diseases of the Chest,*" the study of chest diseases has undergone tremendous expansion. "*Thoracic Diseases, Emphasizing Cardiopulmonary Relationships*" presents this expanded subject in a comprehensive, up-to-date and concise manner. Emphasis on cardiopulmonary relationships, basic pulmonary anatomy and physiology, and pulmonary manifestations of systemic diseases reflect the transformation that has taken place in the study of pulmonary disease during the past two decades.

In keeping with the phenomenal increase in intrathoracic neoplasms, the many aspects of this subject are presented in detail. Sufficient space is allotted to pulmonary tuberculosis, a disease still occupying an important place in the field of medicine. New disease states, for example thesaurosis and alveolar proteinosis, are properly included.

The complete and accurate description of disease states, the frequent reference to case material, and the use of illustrative x-rays make for interesting reading. An intelligently arranged bibliography includes both recent and classic references.

The final section, dealing with the principles of diagnosis, emphasizes the importance of taking a good history and doing careful physical examination of every patient; a physical exercise which, when properly employed, may be very rewarding to the baffled clinician.

In general, *Thoracic Diseases* is an excellent book, one which every physician interested in this subject should have on his library shelves.

Grover Sanders, M.D.

PRACTICAL ANESTHESIOLOGY; by Joseph F. Artusio, Jr., M.D. and Valentino D. B. Mazzia, M.D.; published by the C. V. Mosby Co., St. Louis, Mo.; 318 pages; price, $7.75.

Doctors Artusio and Mazzia have indicated in their preface that this text has been designed for medical students and general practitioners as a handbook of current practices in anesthesiology. They have succeeded in presenting an excellent handbook which should prove useful to students and any medical practitioner who is obliged to administer anesthetics. Since the material is concisely and authoritatively presented, it should be of value to surgeons, obstetricians and medical men, to acquaint them with the current practices and services of this rapidly-growing specialty.

The authors have divided the text into five parts and 43 chapters. In each chapter the subject matter is considered as briefly as is consistent with good journalism and comprehension. There is no great involved detail in any part of the book. Pertinent and current bibliographic references are provided at the end of each chapter. There are a few illustrations which add little to the value of the book.

Throughout the text the authors have diligently adhered to the practice of citing facts relating to the basic sciences and indicating their practical importance. There is no duplication of textual matters and frequent references are inserted in the text to other chapters which may also be pertinent.

One of the most useful chapters (Chapter 32) is but two and one-half pages in length. It is entitled "A few random don'ts in anesthesia." Although it is unusual to find a list of what not to do in the textbooks of today, the reviewer is in accord with citing these admonitions all together in one location. It is certainly as important for a teacher or author to indicate what *not* to do as well as to do. Perhaps the benefit to accrue to patient and physician alike would be greatest should we all learn first what *not* to do.

There is an excellent index which contains multiple cross references. This handbook is recommended reading for physicians or students who wish to be acquainted with the current practice of the specialty of anesthesiology.

Eugene H. Conner, M.D.

INTERPRETATION OF SIGNS AND SYMPTOMS IN DIFFERENT AGE PERIODS: PEDIATRIC DIAGNOSIS; by Morris Green, M.D.; Julius B. Richmond, M.D.; published by W. B. Saunders Co., Philadelphia; 541 pages; price, $13.

The authors of the second edition of Pediatric Diagnosis have made the book current by many changes in the text as well as adding several new chapters which stress symptoms. It stresses the importance of history taking, physical diagnosis and the psychological approach to diseases. It also provides an excellent and current list of references.

The book is a supplement and should not be considered a textbook of pediatrics. We consider the edition a good supplementary book for both the generalist and the pediatrician's library.

Harry S. Andrews, M.D.

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1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.

"As a result of this study, it is our belief that the routine prophylactic use of the combination of meclizine hydrochloride and pyridoxine is a safe and effective method for lessening the incidence of postoperative nausea and vomiting. We are employing this preparation as a routine pre-operative medication."[2]

3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

Study involving 620 patients, 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

[Bonadoxin] "was found clinically effective in the prevention of pre-operative and post-operative nausea and emesis in 157 patients who underwent ocular surgery, while control drugs alone could not completely eliminate the symptoms. Bonadoxin did not cause side reactions in the preoperative or postoperative phase of this study."[5]

6. Bethea, R.C.: International Record of Med. (May) 1960.

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

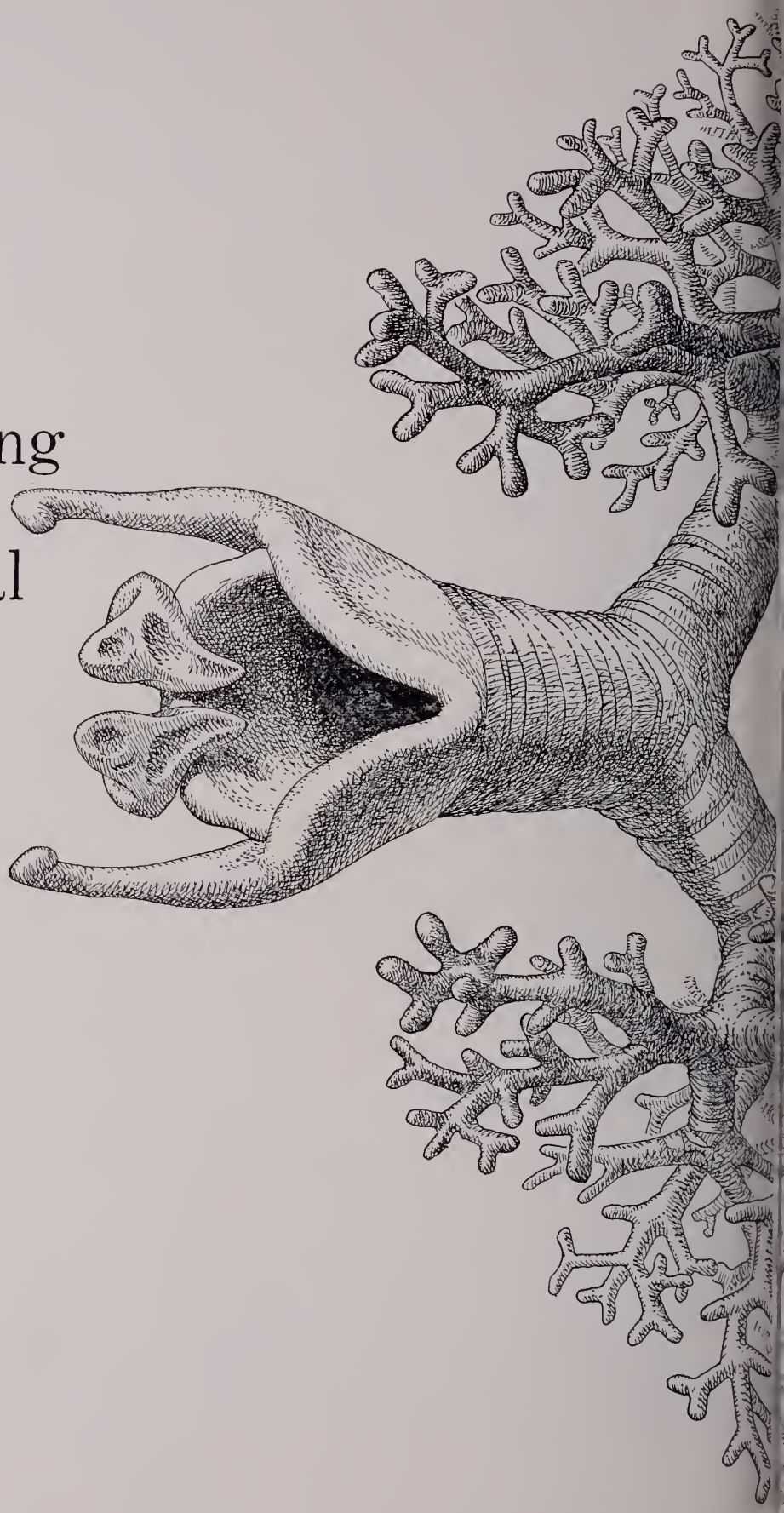
7. Sklaroff, D.M.; Karayannis, N.: Current Therapeutic Research (June) 1962.

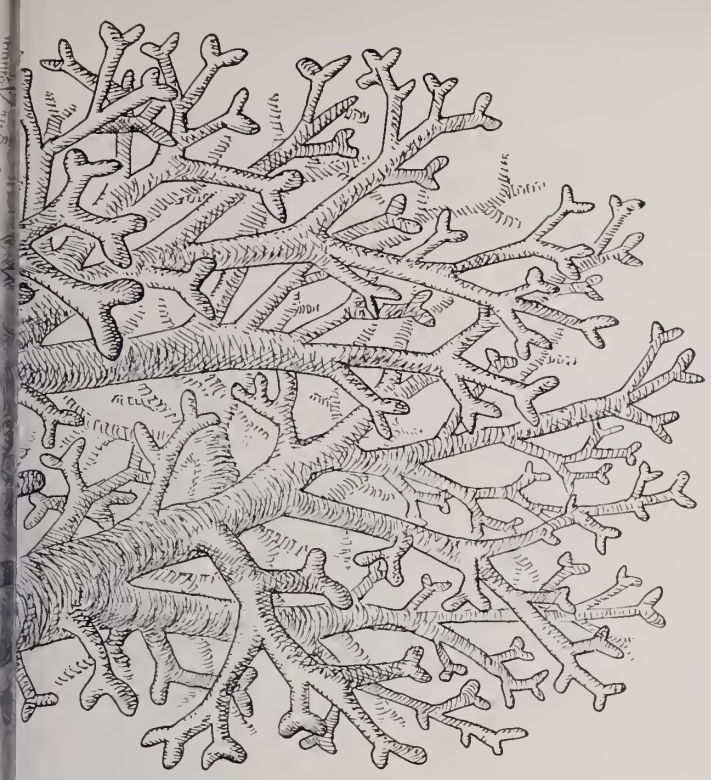
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WASHINGTON NEWS DIGEST

WASHINGTON, D.C.—Influenced strongly by the thalidomide incident, Congress approved legislation giving the Food and Drug Administration more control over the prescription drug industry.

The Kennedy Administration and Senator Estes Kefauver (D., Tenn.), chief sponsor of ethical drug legislation, successfully exploited the thalidomide incident after prospects of passage of a strong drug bill waned.

However, they were unable to get all they wanted in the legislation even with the impact on Congress of the widespread publicity about the clinical testing of thalidomide in this country coupled with reports from Europe of births of malformed children by women who had taken the drug during pregnancy.

One Administration proposal rejected by Congress would have given the Secretary of Health, Welfare and Education authority to require physicians to report directly to him on their clinical tests with new drugs.

The new law empowers the FDA to require "substantial evidence" of the efficiacy, as well as safety, of new drugs before licensing them for marketing. The AMA had warned Congress that this might lead to a test of relative efficacy which could result in potentially-helpful drugs being barred from sale. The AMA contended that the old FDA requirement that a drug live up to its label claims was a sufficient test of effectiveness.

PMA Issues Warning

The Pharmaceuticals Manufacturers Association also warned that drug research might slow down as a result of the new law.

"Some provisions of the new law may not be helpful to the public," the PMA said. "In fact, unless there is the wisest administration of the law harm can be done. For example, medical research may slow down and the costs of medications may increase."

Physicians will be required to get the consent of the patient, or a close relative, for treatment with experimental drugs except in instances where the physician feels that it would not be feasible or would be contrary to his professional judgment. Consent already is a part of the code of ethics of the American Medical Association.

Some other major provisions of the new law:

Authorize the FDA to swiftly suspend any drug which it suspects is dangerous.

Require that the generic name of a drug be printed on the label in type half as large as that for the trade name.

Extends the time during which FDA may review a new drug application before it must be approved or disapproved.

Authorizes the HEW Secretary to establish generic names for new drugs.

Authorizes the HEW Secretary to prevent testing of drugs on humans if he determines there has not been sufficient preclinical testing.

Require batch certification of all antibiotics.

*** *** ***

Congress passed a bill authorizing a $36,000,000 three-year program for federal aid for intensive vaccination programs against polio, diphtheria, whooping cough and tetanus.

The vaccination campaigns are to be aimed primarily at children less than five years old. The U. S. Surgeon General was given broad authority in deciding the amount and terms of federal grants under the program.

Grants to States

Grants will be made to states or, when approved by state officials, to cities or other local governmental units.

Also on the immunization front, a Special Advisory Committee twice recommended to the Public Health Service that Type III oral polio vaccinations be continued for pre-school and school age children but not for adults for the time being.

The Public Health Service accepted the recommendation and urged that communities proceed with planned mass vaccination campaigns using Type III for children. But some communities decided to hold up their mass immunization programs at least temporarily or to suspend Type III doses for children, as well as adults.

The Advisory Committee first made its oral polio vaccine recommendation at an emergency meeting on September 15. The meeting was called after Canada suspended use of oral polio vaccine. The Health Ministry action in Canada, where all three types of the oral vaccine had been given in one dose, was prompted by the occurrence of a few cases of Type III polio. The three types of vaccine are given in separate doses in this country.

There also were at that time a few Type III cases reported in this country among adults who had taken the oral vaccine.

After an October 2 meeting, Luther L. Terry, M.D., Surgeon General of the PHS, said:

"The recommendation that Type III be confined to children has raised the question of spread from vaccinated children to adults, especially family members.

The evidence does not indicate a hazard to adults exposed in this way.

"The level of this risk can only be approximated but clearly is within range of less than one case per million doses. Since the (Type III) cases have been concentrated among adults the risk to this group is greater whereas the risk to children is exceedingly slight or practically nonexistent."

*** *** ***

President Kennedy signed into law H.R. 10 permitting physicians and other self-employed persons to take a federal income tax deduction for private pension plans.

Kennedy signed the legislation less than six hours before the midnight October 10 deadline that he had to act on the measure. If he had not signed it by then, it would have become law without his signature. It appeared certain that a presidential veto would have been overridden.

Physicians represent less than three per cent of the self-employed who could benefit under the new law.

Enactment of the legislation into law climaxed a 12-year battle in Congress. The House passed it twice, in 1958 and 1959, but it died each time in the Senate with adjournment.

This year the House passed it with a 361-0 vote. The Senate vote was 70 to 8.

The new law authorizes a self-employed individual, such as a physician, to contribute up to 10% of his earned income or $2,500, whichever is less, toward a retirement plan, provided he includes all of his employees with three or more years of service under the plan. A tax deduction of half of the contribution to the self-employed person's retirement plan would be allowed.

The contributions made on behalf of employes would be fully tax deductible.

The measure prohibits drawing on the retirement funds without penalty before age 59½, except in case of disability or death.

Public Health Page

(Continued from Page 1018)

How the Medical Profession Can Help

Licensure, the AHA listing program, Blue Cross approval and the proposed extension of the medical care program to nursing homes all require complete medical records for patients in nursing homes. Therefore, every physician having patients in nursing homes is expected to provide for each patient a history, report of physical examination, diagnosis, written orders and progress notes, just as if the patients were in a hospital.

The physician can relieve the problems of the nursing home administrator and possibly prevent him from losing his licensed or desired status by consistently cooperating in this requirement.

Another way in which physicians may help is to refer patients only to licensed nursing homes. Many physicians in our State have failed to distinguish between nursing homes licensed by the State Board of Health and rest homes for the aged licensed for domiciliary care by the Department of Economic Security. Some have even failed to recognize the distinction between licensed and unlicensed ("bootleg") homes.

If a home is not licensed by the State Board of Health, it has not qualified for a license as a nursing care facility. It is an injustice to the patient, to the State and to the legitimate nursing homes who expend the money for meeting requirements, if a patient in need of nursing care is referred to a home unlicensed for the purpose.

Only those homes licensed by the Board of Health may be referred to as "nursing homes" or "convalescent homes" in the legal sense of the word. Many licensed rest homes, homes for the aged and personal care homes are doing a good work, but they may not legally call themselves nursing homes and no one else should consider them as such.

The medical profession can do much toward helping licensed nursing homes improve their care, by informing their patients who are in need of such care, of this distinction between nursing homes and other related facilities and by insisting that homes be chosen that are qualified to care for the types of patients admitted.

Our Political Obligation

(Continued from Page 1060)

the strong. You cannot help the wage earner by pulling down the wage payer. You cannot further the brotherhood of man by encouraging class hatred. You cannot help the poor by destroying the rich. You cannot establish sound security on borrowed money. You cannot keep out of trouble by spending more than you earn. You cannot build character and courage by taking away man's initiative and independence. You cannot help man permanently by doing for him what he could and should do for himself."

James D. Ford, Jr., M.D., has opened an office for the general practice of medicine at Carrollton, Ky. He was graduated from the University of Louisville School of Medicine in 1961 and served his internship at Marion County General Hospital, Indianapolis.

Robert Greenlaw, M.D., Lexington, Ky., has been named a member of the Board of Trustees of the Society of Nuclear Medicine. The Society recently held its ninth annual meeting at Dallas, Texas. J. R. Maxfield, Jr., M.D., Dallas, is president.

Maurice Bowling, M.D., Owenton, Ky., was named "Owen Countian of the Year" by the Owenton Rotary Club. He is a graduate of the University of Louisville School of Medicine and began his practice at Owenton in 1953.

Harry C. Denham, M.D., Maysville, Ky., has been named a representative on the Kentucky Council for Public Higher Education. Doctor Denham is also a member of the Board of Trustees of the University of Kentucky.



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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #125 — The patient was a 39-year-old, married, white gravida 6 para 5 who had been under the care of a private physician. The expected date of the delivery was July 7, 1961, as calculated from the menstrual history.

Obstetrical History

The past obstetrical history was uncomplicated. The patient had been subjected to uterine curettage in July 1951 because of menstrual irregularity. The pathologist reported that the currettings showed only normal, approximately mid-interval endometrium.

She was admitted to the hospital at 3:45 a.m. on August 10, 1961. Initial examination showed the cervix to be long and thick; it was dilated to a thickness of one finger and the presenting part lay at minus 1 station. The blood pressure was 120/86 and the pulse, 92. At 9 a.m. on August 11, there were no uterine contractions and the patient was allowed to go home.

Readmitted to Hospital

She was readmitted in labor at 9:05 p.m. on August 23; contractions were recurring at four-minute intervals and had been painful since 7:30 p.m. On examination, the cervix was dilated to one and one-half fingerbreadths. The blood pressure was 130/88. The patient was given 50 milligrams of Demerol and 1/300 grains of scopolamine intravenously at 9:30 p.m. At 1:30 a.m., another vaginal examination showed the cervix to be two and one-half fingers dilated, with the presenting part at minus 1. The fetal heart beat could not be definitely ausculted. Contractions recurred every three minutes. She was given 50 milligrams of Demerol and 25 milligrams of Phenergan.

At 2 a.m., she had a moderate amount of bright bloody discharge, following which vaginal examination by her physician revealed the cervix to be three fingers dilated. The fetal heart beat continued to be inaudible. The patient seemed unresponsive when she was taken to the delivery room.

The cervix reached complete dilation at 2:30 a.m., and the patient was delivered of an 11-pound, 1 ounce stillborn male infant at 2:43 a.m., by low forceps extraction under general anesthesia. She sustained a cervical laceration in addition to a first degree perineal laceration. The placenta was delivered intact by simple expression at 2:45 a.m.

An ampule of ergotrate was administered during the delivery of the head. Bleeding was described as minimal until 40 minutes after delivery when profuse bleeding was observed; this blood failed to clot.

Oxygen Given By Mask

The patient was given oxygen by mask, an intravenous solution of neosynephrine, Solu-Cortef, caramine and caffeine sodiobenzoate. She appeared cyanotic despite the administration of oxygen under positive pressure. The pulse was faint and could not be counted, and the blood pressure was unobtainable. External cardiac massage was done. Fibrinogen was available at 3:30 a.m. but could not be given because of peripheral venous collapse. The patient ceased breathing at 3:35 a.m. and was pronounced dead.

The cause of death was reported to be abruptio placentae with severe afibrinogenemia. Permission for autopsy was refused.

Comments

The committee considered this to be a direct obstetrical death with possible preventable factors. The diagnosis of abruptio placentae was clinically compatible with the available history.

A cervical laceration extending into the broad ligament was thought to be a possible explanation of the initial absence of excessive bleeding. Uterine atony, the most usual cause of postpartum hemorrhage, was also a possibility, especially in view of the large infant and the high parity of the patient.

The case demonstrates the value of starting intravenous fluids at each delivery. Such a routine may save valuable time in the event of a hemorrhagic emergency.

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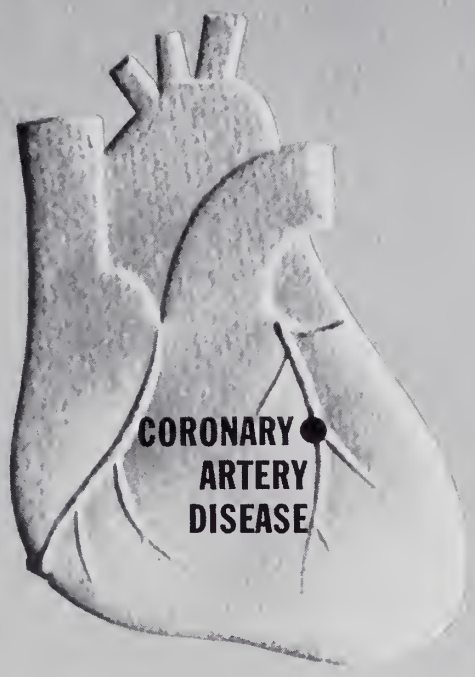
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KENTUCKY STATE MEDICAL ASSOCIATION
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when urinary tract infections present a therapeutic challenge...

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Often recurrent... often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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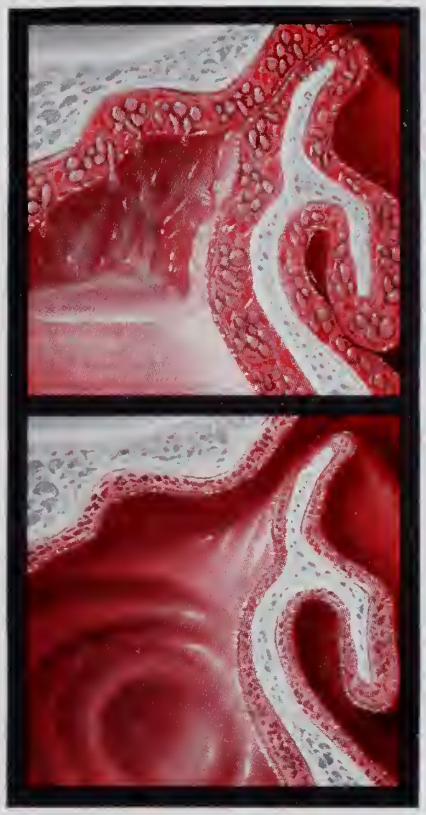
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In colds and sinusitis

unsurpassed in providing drainage space without chemical harm



The clogged sinus
In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

The normal sinus
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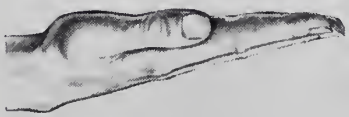
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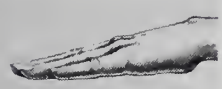
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MESSAGE FROM THE PRESIDENT

Medical Profession Needs Dedicated Workers

THIS month is the end of the calendar year. It's time to take stock of our standing and make definite plans for 1963.

Most county societies elect new officers in December or January. Our medical organization is no better nor worse than its members. We are all dedicated to the practice of medicine. However, some are more willing to work for the organization.

It is well to enter into community affairs: Your church, a service club, PTA, Boy Scout activities, attend your high school athletic games and other activities. Your county society needs you, too.

George Sehlinger, M.D., stated it so well in the Jefferson County Medical Society Bulletin when he said: "Each member of the Society should attend the monthly meetings to exercise his rights in and to derive his benefits from the Society. Attendance should not be determined solely by the attractiveness of the program, but rather by an active interest in the Society affairs and policies.

Our organization needs dedicated workers, so keep this in mind in selecting your leaders for the next year. The profession has done so much for you, it is time for you to do more for the profession.

David M. Cox



The good life–just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruits or juices.

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THE INSURANCE PAGE



Growth and Improvement of the Blue Shield Program

HAVING recently completed two years as president of the board of directors of Kentucky Physicians Mutual, Inc., it is of interest to look back and comment on the rapid growth of the Blue Shield program in Kentucky and to look forward and list the improvements and progress now in effect and those planned for 1963.

Kentucky Blue Shield Started in 1949

The Kentucky State Medical Association started the Blue Shield program in Kentucky in 1949 as a non-profit pre-payment plan for surgery, accident cases and maternity benefits and later improved it by making available a rider for in-hospital medical cases. This plan now known as the Standard Contract grew rapidly in enrollment and because of inflation since 1949 has become partially inadequate, but is continued as a low-cost "indemnity plan."

The higher level benefits of the Preferred Plan were at first offered only to groups, but in the past two years the Plan has been available to individuals. This was a step forward in the continuing effort to upgrade the benefits in order to adjust to inflation. As of September 30, 1962, 208,891 people were covered under Preferred Blue Shield schedules.

Enrollment continues to grow rapidly but should level off in the future. 782,416 people were members as of September 30, 1962, and this continues to grow month by month.

Quality of Benefits Upgraded

The quality of the benefits offered has been upgraded continuously. Higher level medical benefits for the non-surgical patients were developed, so that now there is a choice of three medical riders from a low to a high level schedule of benefits.

The program of new endorsements for Extended Benefits and Major Medical offered in the past year was eagerly accepted by the public. As of September 30, 1962, 26,435 persons were covered under the Extended Benefits program by 537 companies, and 7,036 persons were covered by Major Medical.

The KSMA Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., chairman, has instigated and encouraged these new programs.

A new *All Inclusive Contract* which is a combined Blue Cross-Blue Shield package is now being developed and will be available soon. This will offer the following:

What New Contract Offers

1. Comprehensive Blue Cross coverage.
2. New revised Preferred Blue Shield Plan.
3. Preferred Anesthesia schedule.
4. A high level In-Hospital Medical with Intensive Care and Consultations.
5. Out-of-Hospital Diagnostic X-ray and Laboratory.
6. Radiation Therapy.

All Contracts Recently Revised

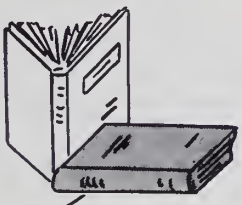
The most salient recent achievement is the entire revision of all contracts, using the Physicians Service Index developed by the National Association of Blue Shield Plans. *At the time the respective contract years expire in 1963, subscribers will be changed to these new more equitable schedules. Complete change-over will take more than a year.* The revision was accomplished after a great deal of work by the administrative staff and by the Medical Advisory Committee of the Blue Shield board, Richard Rust, M.D., chairman.

The Kentucky State Medical Association can give credit for the able management of Kentucky Physicians Mutual to D. Lane Tynes and his capable staff. Blue Shield has also prospered because of a very practical partnership with Blue Cross. The future will show that the Kentucky Blue Shield program will be continually improved to meet the needs of the times.

John Dickinson, M.D.

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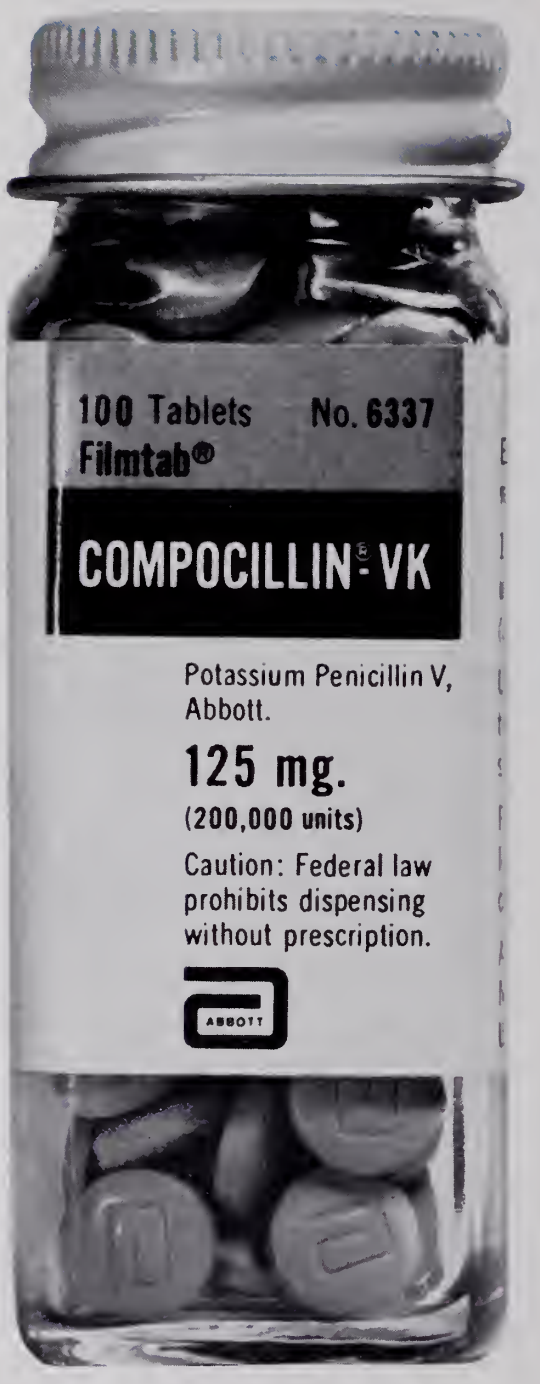
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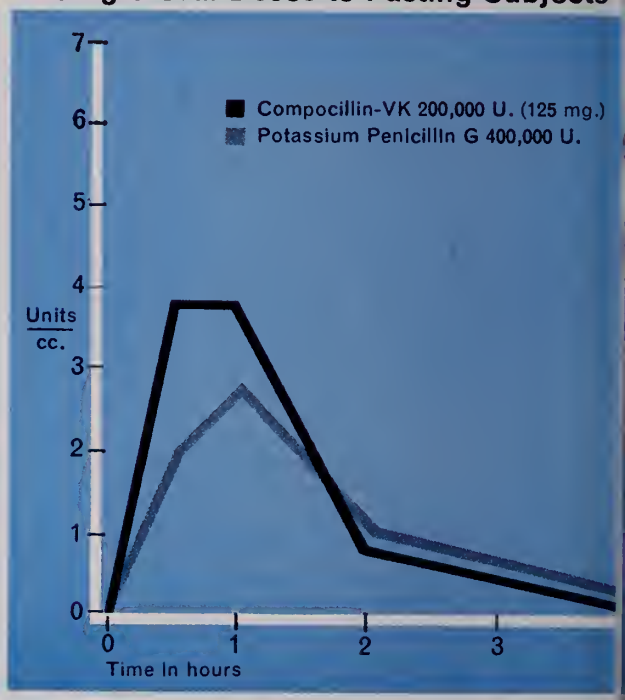
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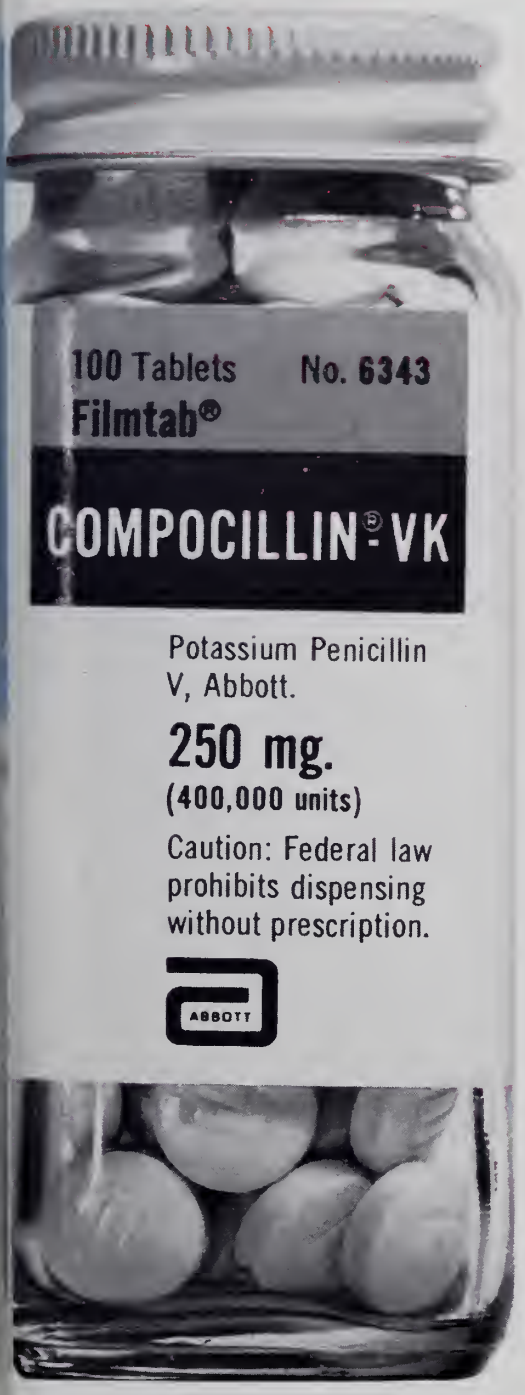
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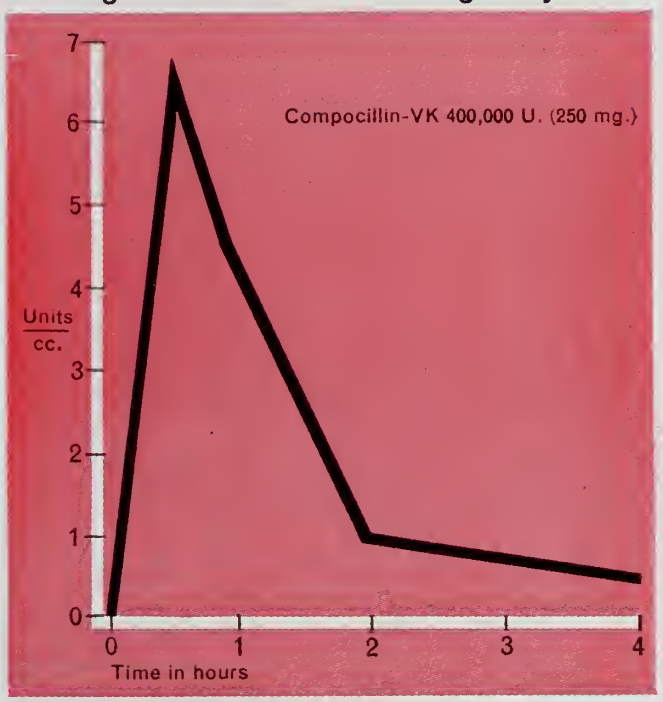
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WASHINGTON NEWS DIGEST



WASHINGTON, D.C.—A Public Health Service study of possible links between cigarette smoking and lung cancer got underway with appointment of a 10-member advisory committee including eight physicians from the academic field.

Luther L. Terry, M.D., surgeon general of the PHS and chairman of the committee, said he selected the 10 members on the basis of geographic distribution and balance among professional disciplines, scientific objectivity, competence in special fields of interest, ability to think broadly outside of one particular field of interest, and ability to critically analyze a point of view.

In addition to being a committee member, Stanhope Bayne-Jones, M.D., also is serving as a special consultant to the committee staff. He is a former dean of the Yale School of Medicine and a former president of the American Society of Pathology and Bacteriology.

"This committee is not merely an aggregate of 10 men," the Surgeon General said. "It is a composition of specialists covering the broad range of medical sciences involved in evaluating the complex relationship between tobacco smoking and health. I expect the committee to be a dynamic, productive and creative group that will shed light on these complex questions."

The committee members were selected from a list of approximately 150 names submitted by federal agencies, voluntary health organizations and the tobacco industry.

In the first phase of its activity, the committee is making a comprehensive review of all available data on smoking and other factors in the environment that may affect health. It is expected that this review will be completed by next summer.

The second phase of the study will concern recommendations for action. No decision on how the second phase is to be conducted will be made until the first phase has been completed.

Soon after appointment of the committee, the National Cancer Institute under PHS issued a new booklet, "Cancer Cause and Prevention," which referred to the conclusion reached by the PHS in 1959 that smoking is the principal reason for the steep rise in lung cancer cases.

The booklet discusses cancer as a preventable disease. It describes environmental and personal factors involved in the causation of cancer, and occupational cancer hazards that to some extent may be avoided. It goes into the problems of air pollution, radiation exposure and food additives.

The booklet points out that as the older age group in the population increases, more people are living long enough to develop cancer induced by exposure to a causative agent earlier in life. Such cancers may take as long as 40 years to appear, it says.

"Thus," the publication concludes, "mortality from malignant disease in the future can be reduced by continuous identification and eradication of cancer hazards."

* * * * * * * * *

The Food and Drug Administration was criticized as to both policies and operation by a Citizens Advisory Committee and some members of Congress.

A special advisory committee—appointed by the Secretary of Health, Education and Welfare and headed by Dr. George Y. Harvey, a political science lecturer at the University of Missouri—said the FDA had fallen short in carrying out its responsibility of protecting the American public against unsafe drugs, therapeutic devices and foods.

The FDA came in for even sharper criticism from Senator Hubert H. Humphrey (D. Minn.), who indicated his Senate Government Operations Subcommittee would hold hearings in December on the agency. He charged the FDA lacks the ability and competence to carry out the new drug law effectively.

He accused the agency of failure to keep in touch with other government health projects and outside experts.

"Drugs have been approved which FDA now admits should never have been approved," Senator Humphrey said. "Drugs have been kept on the market long after FDA admits they should have been eliminated from the market."

The 16 doctors, educators, businessmen and consumers on the advisory committee reported to HEW Secretary Anthony J. Celebrezze after a year-long study on FDA programs and procedures.

Making 10 major recommendations for overhauling FDA's approach to consumer protection, the panel said the federal agency had been relying on "after-the-fact enforcement" of regulations rather than taking more preventive action.

Secretary Celebrezze promised that the report would get a "most careful analysis." He said steps already were being taken to assure the public adequate protection through administrative action and under the new drug safety law recently passed by Congress.

"Although inspection and punitive action are vitally necessary," the committee said, "the time has arrived for a more constructive approach. 'After-the-fact enforcement' is not always good consumer protection. Other approaches along preventive lines should be developed."

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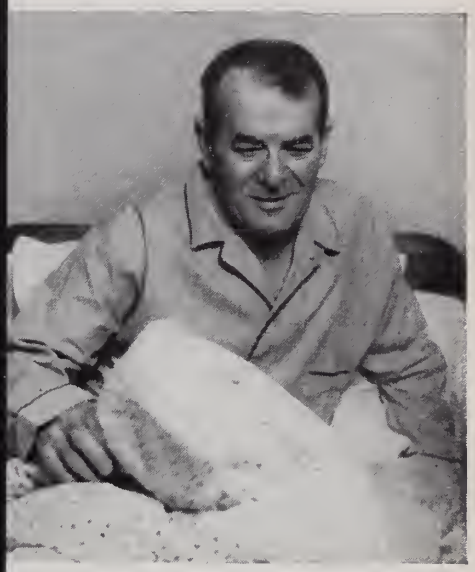


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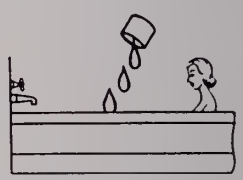
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VOLUME 60 DECEMBER, 1962 No. 12

Discriminating Use of Endocrine Tests*

(Continued from the November Journal)

IRVING F. KANNER, M.D.

Lexington, Ky.

Practical methods of estimating the function of most endocrine glands are presented. When the history and physical examination are suggestive, such tests, discriminatingly used, help diagnose many endocrine diseases.

Adrenal Cortex

Hyperplasia and tumors of the adrenal cortex may be associated with excess production of cortisol, sex hormones or aldosterone.

Cushing's Syndrome

Cushing's syndrome may be associated with excess production or administration of ACTH; adrenal tumors, or, more commonly at present, may be iatrogenic. It may also occur in association with malignant tumors of non-endocrine organs.

Glucose intolerance is common, though acidosis is rare. Urine specific gravity is usually low and may show findings consistent with hypertension. Anemia suggests malignancy, since polycythemia is common, along with eosinopenia, relative lymphopenia, and, at times, hypokalemic, hypochloremic alkalosis. The serum sodium may be elevated. Skull x-rays may show changes in the sella turcica, while other films may show osteoporosis, and even evidence of tumor. Pneumographic studies of the adrenals are as apt to mislead as to help and are unnecessary if the abdominal surgical approach is to be used.

The characteristic finding is the elevation of the 17 hydroxysteroids in both blood and urine. Twenty-four hour urine collections are necessary, due to the diurnal variation of cortisol secretion, which is highest in the early morning. A wise precaution in testing any 24-hour urine collection is to run a quantitative creatinine on each specimen. Creatinine excretion of each individual varies little from day to day, and by checking it the possibility of errors in urine collection can be found.

At present, the recommended method of assay is the Porter-Silber chromogens of the 17 hydroxysteroids[10], rather than the 17 ketogenic steroids by the Norymberski technique. There are certain theoretical advantages in measuring the plasma corticoids, if measured at different hours of the day. At times both urine and blood levels may be run, but the urinary assay is adequate for practical purposes.

When the test is elevated, additional information may be obtained by repeating the measurement after ACTH stimulation and after suppression with dexamethasone. Normal people will have a 10-25 mgm rise in 17 hydroxysteroid excretion after an eight-hour intravenous of 25 mgm ACTH in 1000 ml of 5% glucose in water, while patients with adrenal hyperplasia will show a three to four times increase over control values. Most patients with adrenal tumors will show little response.[11]

Dexamethasone suppression test:

1. 24-hour urine output of 17 hydroxyster-

*Lecture at Postgraduate Course on Endocrine Disorders, January 25, 1962, at the University of Kentucky Medical Center, Lexington, Ky.

oids measured for two days before test, and daily during dexamethasone administration.

2. 0.5 mgm dexamethasone given orally every six hours for two days.
3. If little change in 17 hydroxysteroids, test continued with 2.0 mgm dexamethasone every six hours for two or three more days.
4. Interpretation: Normals reduce 17 hydroxysteroid output to less than half of control values in two days, and to less than 2.5 mgm/24 hours. In Cushing's syndrome with adrenal hyperplasia, high basal levels, which do not drop till higher dose used and then drop 50%. With tumor, high basal levels do not fall with either dose.[12]

As mentioned earlier, there are exceptions, and tumor cannot certainly be ruled out by these means. Most recently SU-4885 (Metapyrone®), an analogue of Amphenone B®, has been used as a test of pituitary reserve. This compound impairs the synthesis of cortisol, with a resultant increased output of Compound S or 11-desoxycortisol. Compound S will not inhibit the pituitary output of ACTH, and therefore, if the pituitary is capable of responding, more ACTH is formed. This stimulates the adrenal, which secretes more Compound S, which, with its tetra-hydro derivative, is found therefore in the urine in increased amounts. These are measured as 17 hydroxysteroids. The test is as follows:

1. 500-750 mgm SU-4885 given orally every four hours for six doses.
2. Total urinary excretion of 17 hydroxysteroids/24 hours, measured day before and day of test.
3. Interpretation: Normals show a 10 to 25 mgm rise. Cushing's syndrome from adrenal hyperplasia shows a normal rise, those with tumors do not. When the pituitary reserve is limited, rise is only 0-3-4 mgm.[13]

It is becoming important to distinguish adrenal tumors from hyperplasia, as we now have ways of suppressing cortisol production, as with o p' DDD (ortho para Dichloro Diphenyl Dichloroethane) and triparanol (MER 29®), with alleviation of Cushing's syndrome.

Cushing's syndrome due to tumors of other organs should be borne in mind, and sought for when indicated.

Addison's Disease

Inadequate production of cortisol may be due to primary adrenal insufficiency, or may be secondary to decreased ACTH production by the pituitary. The latter may be part of a generalized panhypopituitarism; or, quite commonly, may follow corticoid administration. One type of adrenal insufficiency may be due to an enzymatic block, such as can be produced artificially with SU-4885, and is part of the adrenogenital syndrome, which will be discussed later.

When laboratory means are needed to differentiate primary and secondary Addison's disease, the response to repeated intravenous ACTH stimulation in the secondary form will indicate the adrenal is intact.

Eosinophilia over 300 is usually present in adrenal failure, except in panhypopituitarism. The eosinophilic response to ACTH is of no value. There is usually a relative lymphocytosis, some anemia, mild neutropenia, hyponatremia, hypochloremia, hyperpotassemia, and, at times, azotemia. Fasting blood sugars may be low, and the glucose tolerance test tends to be flat. When the adrenal insufficiency is part of the picture of panhypopituitarism, the blood sugars may be quite labile. The serum sodium: potassium ratio is usually less than 30 in Addison's disease.

The best screening procedure for Addison's disease is Soffer and Gabrilove's modification of the Robinson-Kepler-Power water-loading test:

1. 1500 ml tap water is given in 15-20 minutes.
2. Urine is collected for five hours.
3. Interpretation: Normals excrete 1200-1900 ml in five hours. Patients with adrenal insufficiency excrete less than 800 ml. False positives occur from faulty intestinal absorption or faulty renal excretion.[14]

Although the 17 ketosteroid assay may be depressed, the definitive test is the measurement of the 17 hydroxysteroids in the blood or the 24-hour urinary excretion, both of which

are below normal in Addison's disease and fail to rise after repeated ACTH stimulation in the primary form. Normal people show a 50% rise over basal levels after ACTH.

Adrenogenital Syndrome

Various defects in the synthesis of cortisol can occur, with resultant formation of excessive amounts of androgenic hormones and pregnanetriol, and occasionally of estrogens. Many varieties of the adrenogenital syndrome occur, depending upon the sex and age of onset, as well as the particular enzymal defect. These include pseudohermaphrodite, hypertensive, salt-losing and febrile varieties, as well as adrenal virilization. It is disputed whether the Stein-Leventhal syndrome is due to adrenal hyperplasia.

In children with adrenogenital syndrome, x-rays for bone age will show marked advancement. The principal laboratory finding is the elevation of the 24-hour excretion of 17 ketosteroids, which in women does not normally exceed 14 mgm/24 hours. In some patients, although the 17 ketosteroid level is within normal limits, the fraction representing the more active androgens may be elevated. When this is suspected, fractionation of the 17 ketosteroids is indicated. Various means of such fractionation are being used, most being chromatographic. We are trying a simple method of fractionation, by varying the solvents used, but unfortunately have as yet insufficient experience for evaluation. Since pregnanetriol excretion in the urine is usually elevated in this condition, assays for this metabolite should be performed when the 17 ketosteroid output is normal. Carcinoma of the adrenal associated with masculinization may be indicated by a high "Allen Test" for dehydroepiandrosterone by a high Beta fraction after digitonin precipitation, or by high estrogen excretion combined with high 17 ketosteroid excretion.

Suppression tests with dexamethasone, and stimulation tests with ACTH will be reflected in the output of 17 ketosteroids and pregnanetriol in normal patients, and those with adrenal virilization, but usually not in patients with tumors. In the salt-losing variety of this syndrome, serum sodium will be low. This is accentuated after ACTH, which may even produce acute adrenal insufficiency. Assays for Compound S (11 desoxycortisol) are useful in the hypertensive variety of this syndrome. Since this compound is measured as a 17 hydroxysteroid, the assay will be higher than in other forms of the adrenogenital syndrome, in which it is usually slightly lower than normal. Chromatographic techniques are useful in this variety for definitive assay.

A form of this syndrome with periodic fever seems to be related to excessive production of etiocholanone.[15] Chromatographic techniques will be needed to make the diagnosis, if the total 17 ketosteroid and pregnanetriol assays are within normal limits. The elevated etiocholanalone excretion may only be present during febrile episodes.

In differentiating the true and pseudohermaphrodites, it is often of value to determine chromosomal sex, by staining tongue-blade scrapings of the buccal mucosa. When the presence of ovulation is in doubt, vaginal spreads, basal temperature charts, and studies of cervical mucus, which will be discussed later, can help determine if ovulation is normal.

Adrenal Medulla and Pheochromocytoma

The significant hormonal tumor sought for in the adrenal medulla, or in accessory sites, is the pheochromocytoma. This tumor produces excesses of either epinephrine or norepinephrine, or both. It may cause either paroxysmal or sustained hypertension. Various bedside and chemical tests have been devised, but none are 100% effective in diagnosing the borderline case. Glucose intolerance or frank diabetes may be present. The BMR may be elevated, but the PBI and RAI are normal.

Tests employing agents such as histamine and mecholyl, intended to stimulate pheochromocytomas during periods of normotension, are misleading, dangerous and should not be used.

Of the bedside tests, phentolamine (Regitine®) is the best.[16] Sedatives, especially reserpine, cause false positives, and the latter may do so for a month after its last administration. False negatives as well as false positives occur.

The 24-hour urinary excretion of catecholamines may be diagnostic. Most patients with pheochromocytomas will excrete over 50 mcgm in 24 hours, but levels over 35 are suspicious.

Patients must not use nose drops for 24 hours before, and during the test, as these may falsely elevate values.

Most recently, the determination of vanillyl mandelic acid[17] or VMA in the urine has been used. VMA is 3 methoxy-4 hydroxy mandelic acid, the end product of the degradation of both epinephrine and norepinephrine. The test requires only simple equipment, and qualitative tests may be run on individual, random urine specimens. The assay will show less than 10 mgm/24 hours in the urine of normal people. Many medicines, and bananas, interfere with the test, and should be withheld for 48 hours before the test.

Unfortunately, anxiety will produce elevated values with either chemical test, which may overlap some of the cases of pheochromocytoma.

Gonads

The pituitary secretes at least three hormones which have direct effects on the gonads. These are:

1. Follicle stimulating hormone (FSH).
2. Luteinizing hormone (LH), called, in the male, interstitial cell stimulating hormone (ICSH).
3. Prolactin (Luteotrophin) (LTH).

The only practical assay we have for clinical use is the so-called FSH titer, which actually measures both FSH and LH together, so that a patient may have a normal FSH titer, yet be lacking in LH.

FSH Titer

The FSH titer is especially helpful in differentiating primary from secondary gonadal failure. It is elevated in primary gonadal failure, and low to low-normal in failure secondary to pituitary defect. However, it may also be low in nutritional deficiency, including anorexia nervosa. Exogenous estrogens, but not usual doses of testosterone, depress the titer promptly by inhibiting the pituitary. Similarly, feminizing ovarian tumors also lower the titer. High elevations of FSH titer are obtained in chorioepitheliomas; mixed epitheliomas of the gonads; seminomas; and during pregnancy, especially from the second or third to the 16th weeks. In all of these conditions the test for chorionic gonadotrophin is a less expensive procedure. I have previously mentioned alteration in FSH excretion with other pituitary lesions.

Normals for FSH vary with different laboratories, and with age, sex, time in the menstrual cycle, and from puberty to menopause.

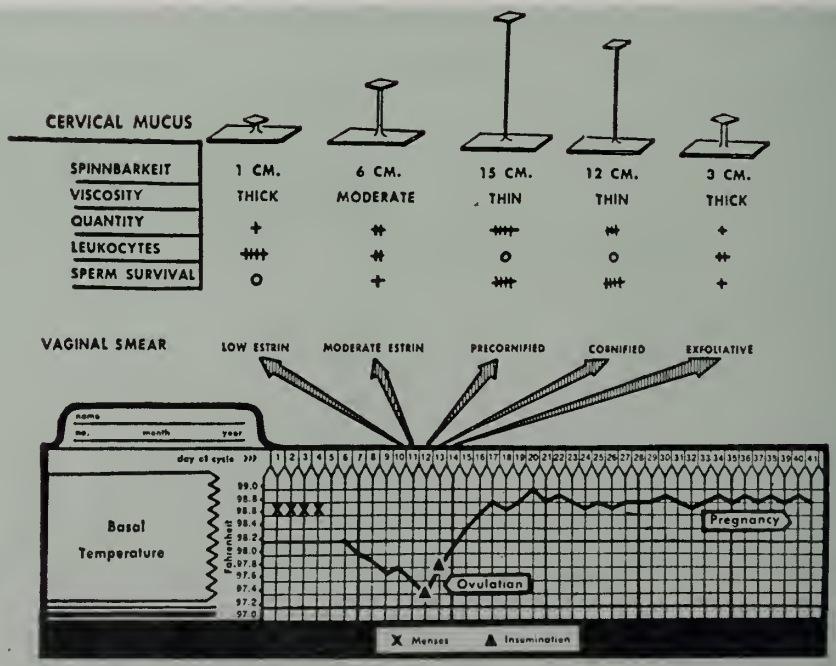


Fig. 3. Diagram showing correlation of basal temperature, vaginal smears and cervical mucus tests during a normal menstrual cycle. (Cohen, M., Stein, I., and Kaye, B.: Spinnbarkeit: characteristic of cervical mucus; significance at ovulation time, Fertil. & Steril. 3:201-209)

TABLE 1. CLASSIFICATION OF ESTROGEN EFFECT BY VAGINAL CYTOLOGY AND URINARY BIO-ASSAY

Estrogen Effect	Cellular Description	Histologic Type	Approximate Urinary Estrogen Excretion M.U./24 Hours*	Characteristic Physiologic State
"0"	Basal & parabasal cells only	Markedly atrophic	Less than 6	Early childhood, some postmenopausal women
"1"	Parabasal & Intermediate cells	Atrophic; Very little proliferation	6 to 22	Childhood, postmenopausal
"2"	Chiefly intermediate, some parabasal & cyanophilic superficial cells	Intermediate proliferation	22 to 44	Late childhood, postmenopausal
"3"	Chiefly superficial cyanophilic cells, low E.I. & K.I.,† some intermediate cells present	Moderate	44 to 66	Early follicular phase
"4"	Chiefly superficial cells with a moderately high E.I. & K.I.	Highly proliferated	66 to 132	Mid-follicular to pre-ovulatory phase
"5"	Practically all superficial cells with very high E.I. & K.I.	Highly proliferated	More than 132‡	Pre-ovulatory and ovulatory phase

* Allen-Doisy assay, after acid hydrolysis and CCl_4 extraction.
† The precise eosinophilic and karyopyknotic index may be included if desired.
‡ The vaginal smear response usually reaches peak at excretion levels of 200 m.u.
Rakoff, A. E., in Sunderman and Sunderman—Lipids and the Steroid Hormones in Clinical Medicine. Lippincott, p. 185, 1960

Chorionic Gonadotrophin

Many animals are used for the assay of chorionic gonadotrophin, the most popular today being certain species of male frogs. New immuno-assay techniques are available, one being commercially available under the name of Ortho® Pregnancy test. It is too soon to tell whether this simple test or other modifications will replace the animal assays.

We have already mentioned this hormone in connection with pregnancy and certain tumors. Chorionic gonadatrophin disappears in the urine after intrauterine death and after normal delivery. Persistent positive assays are present with retained placental fragments and, with rising titer, with chorionepitheliomas and hydatiform mole. In males, values under 1000 mouse units have been associated with relatively benign tumors, while values over 10,000 are found with chorionepitheliomas.

Ovaries

The normal ovaries secrete both estrogenic hormones and progesterone, the levels depending upon the stage of the menstrual cycle.

The most common reasons for estimation of the secretion of female hormones are to aid in differentiating causes of menstrual disorders and infertility. There is also some value in estrogen assays in the diagnosis of granulosa cell tumors, and of feminizing syndromes (in men) associated with adrenal hyperplasia and tumors. Estimation of pregnanediol excretion, as an indicator of placental function in threatened abortion after the 16th week, may help to determine the need for progesterone supplementation.

Often adequate estimation of estrogen and progesterone secretion is available from examination of cervical secretions, vaginal spreads, basal temperature curves and endometrial biopsies. Cervical secretions are examined for stretchability or spinnbarkeit, leucocytes and ferning.[18] The latter is the microscopic pattern made by cervical secretions dried on a glass slide when estrogen effect is adequate. It disappears when progesterone effects take over, later in the cycle. When these examinations are made throughout the menstrual cycle, excellent evidence of ovulation and the presence of estrogen and progesterone are obtained (Figure 3). Cervical infection, unfortunately, may void such estimations. Qualitative estimation of progesterone secretion is presumed when cervical mucus tests which previously showed high estrogenic effects become thick, cellular, tenacious and show a negative fern test for the 13 days preceding menstruation. The basal temperature chart also furnishes evidence of ovulation and progesterone effect.

Stained vaginal smears may allow nearly quantitative estimation[19] of estrogen level within certain limits (Table 1). If these simple tests show adequate evidence of estrogenic and progesteronic effects, there is little need for complicated assays for these hormones. Other causes must then be sought for menstrual dis-

orders or infertility, including such diseases as the adrenogenital syndrome and Stein-Leventhal syndrome.

When sexual development does not occur as expected in the female, Turner's syndrome may be suspected. Eighty per cent of these will be chromosomal males. If the patient does not have Turner's syndrome, one must rule out intracerebral lesions, which will include the use of roentgenograms of the sella turcica. If these studies are negative, FSH tests will help to determine if the primary defect is ovarian, since it will be elevated in such cases.

If adolescence is normal, except for failure of menstruation to appear before age 17, or even later, many will have no evidence of intracranial disease. In these, hormone studies will rarely help.

Adrenal-cortical-like ovarian tumors do occur, with high 17 ketosteroid excretion, not depressable with exogenous cortisone.

When the menarche has appeared, followed by amenorrhea, and the pelvic examination is negative, intracerebral lesions should first be ruled out. The syndromes of polycystic ovaries, one of which is called the Stein-Leventhal syndrome, should be considered. In some of these there is elevated FSH titer, while in others the excretion of 17 ketosteroids, or at least the more androgenic fractions, will be increased. These patients may be helped with small doses of prednisone.

Testes

Leydig cell tumors of the testes will elevate the 17 ketosteroid excretion, while other testicular tumors, as previously mentioned, will cause increased excretion of chorionic gonadotrophins.

Testosterone deficiency may be primary, or secondary to pituitary insufficiency, the manifestations varying with the age of onset. It must be remembered that two-thirds of the normal male 17 ketosteroid secretion is derived from the adrenal cortex, and that fairly normal levels of excretion may occur in the absence af any contribution from the testes. When the defect is primary in the testes, the FSH titer will be elevated; when secondary to pituitary disease, the titer may be low or normal. Lack of testosterone will depress the BMR. Semen examination will show absence of sperm and a low fructose. If the epiphyses are still open, bone age will be retarded. The acid phosphatase level in prostatic secretion in boys and young men can be used for evaluation of androgen activity by the method of Kirk.[20] In Klinefelter's syndrome, while the FSH excretion is high, testicular biopsy reveals the Leydig cells to be normal or hyperplastic, but azoospermia is present. In this syndrome, the male equivalent of Turner's syndrome, the chromosal sex is female.

Comment

Thorough examination of the patient and an adequate history will avoid much unnecessary laboratory work. Roentgen studies and laboratory assays should be used judiciously, the simpler ones being used for screening whenever possible. It must be remembered that multiple defects may be present, as in hypopituitarism, and that multiple glandular adenomas are being found.

When the diagnosis is in question and laboratory results are not diagnostic, it is well to review the classic characteristics of the suspected disease. It may then be wise to take one of two choices. First is to re-examine the patient at intervals of one to six months, with instructions to return sooner if new complaints develop. The other choice is to look further for the site of the defect, if hormone production is altered. The primary site may be in the brain, especially the hypothalamus, in the pituitary, the target gland, body cell or end-organ responsiveness, or in the metabolism of the hormone, as by the liver. Therapeutic trials are generally to be avoided.

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Celiac Disease: Response to Gluten-Free Diet*

N. D. Datta Banik, M.D.**

A case of celiac disease which responded to a gluten-free diet regimen is presented; oral glucose tolerance test and other points of diagnosis are discussed.

Dicke[1], in 1950, demonstrated the sensitivity for wheat of patients with celiac disease. It was proved that the harmful effect lay in the protein fraction (gluten) of wheat and rye flour. The harmful effect of gluten has been confirmed by many European investigators.[2-9]. The treatment has since become simpler and more efficient and the prognosis more favorable. The main therapeutic principle is to give a diet normal in all respects except for the strict avoidance of gluten-containing foods. It has been demonstrated that the harmful effect is caused mainly by the gliadin fraction of gluten[10-12]. It has been further demonstrated that this harmful effect is related in some way with the glutamine fraction of gliadin[13].

The American literature, however, has reported different hypotheses and different methods of treatment[14-20]; and moreover the role of gluten has been questioned[21]. Few cases of treatment with a gluten-free diet have been reported in this country[22]. It is the purpose of this paper to present a case of celiac disease which responded well to the gluten-free diet.

Case Report

D. S., a three-and-one-half-year-old white male, was admitted to Children's Hospital, Louisville, Ky., December 31, 1958. The chief complaints on admission were recurrent episodes of diarrhea with large, pale, foul, bulky stools, and failure to gain weight. His illness dated back to early infancy. At age six months he was occasionally noted to have frequent stools of the character described. From the age of one year on, the diarrhea was progressively worse except for a period of two to three months, during which he had none. His gain in weight was very slow.

Past History: Pregnancy and delivery were unremarkable. Birth weight was nine pounds, three ounces. He was a bottle-fed baby, and when started on solid foods at about four months of age, disliked it. His growth and development were somewhat slow. He sat without support at eight months, walked with support at 13 months, and started to walk without support at 22 months. The family history was negative.

Physical Examination: On admission he was a chronically ill, irritable child. He was markedly malnourished and emaciated. (see Fig. 1).

His weight was 20 pounds and height was 34 inches. His physical growth and skeletal maturation were notably retarded. The significant physical features were unhappy facies, hollow cheeks, inelastic skin, thin extremities,



Figure 1. Photographs of the child before starting treatment. Three standard somatotype views of the patient at three years and nine months of age. Markedly protuberant abdomen, emaciated body and wasted gluteal muscles are prominent.

*Presented at the annual conference of residents, Department of Pediatrics, University of Louisville School of Medicine, Louisville, Ky., March 14, 1960.

**At the time this paper was written, third year resident in pediatrics and senior research fellow, Child Development Unit, Department of Pediatrics, University of Louisville School of Medicine, Louisville, Ky.

TABLE 1. GLUCOSE TOLERANCE TEST

	Time	Blood Glucose (mg %)
Fasting	..	78
After ½ hr.		114
" 1 hr.		110
" 2 hrs.		100
" 3 hrs.		70

wasted buttocks and markedly distended abdomen (circumference 53 cm.). There was no visceromegaly or evidence of fluid in the abdomen. There was moderate pitting edema of dependent parts.

Laboratory Studies: Hgb. 12 gm/100 ml. W.B.C. 17,750 /cu.mm. Myelo-2%, Juvenile-3%, Stab-21%, Seg.-48%, Lymphs.-19%, Mono. 7%. Blood chemistry: Total serum protein 5.4 gm/100 ml., albumin 2.1 gm/100 ml., globulin 3.3 gm/100 ml.; calcium 4.3 mEq/liter; sodium 135 mEq/liter; potassium 3.4 mEq/liter; chloride 104 mEq/liter; carbon dioxide 26 mEq/liter; pH 7.54; N.P.N. 28 mg/100 ml.; cholesterol 107 mg/100 ml.; serum alkaline phosphatase 3 Bodansky units. Urinalysis: Nothing significant. Stool: Microscopically: frothy, foul-smelling and bulky. There were no parasites, ova or giardia cysts. Stool culture was negative. Sweat chloride test: 4.6 mEq/liter. Duodenal drainage for amylase activity revealed 5 c.c. of starch being digested by 1 c.c. of duodenal fluid. X-rays: Chest was normal. Upper G.I. series showed dilation of the small bowel loops, with segmentation. Figure 3 shows the x-ray pattern of small bowel. The results of an oral glucose tolerance test are noted in Table 1. Figure 4 shows the glucose tolerance test graphically. (See next page.)

Treatment and Course: On admission, the patient seemed to be weak and refused to walk but his appetite was good. He was placed on a gluten-free diet. The initial diet consisted of skimmed milk and fresh banana which he liked very much. Then gradually other items such as cheese, vegetables, rice, and meat were added to the diet. After 20 days, the child was allowed to take a free diet except food containing gluten.



Figure 2. Photographs of the child after a gluten-free diet for 30 days. Three standard somatotype views of the patient at three years and 10 months of age. Marked improvement of general appearance and some appearance of fat in the gluteal regions are prominent features.



Figure 3. Upper G. I. Series: The small intestine is somewhat dilated with clumping and segmentation of the barium column.

After one week of treatment, the number and character of stools were improved. He started walking after 20 days of treatment. His activity increased markedly with a concomitant improvement of his previous irritable nature. He seemed to be cheerful and agreed to go to the play room. The edema over the dependent parts gradually disappeared, while the size of the abdomen appreciably diminished. (Circumference was reduced from 53 cm. to 48 cm.)

During his hospital stay, he gained weight from 20 pounds to 25 pounds. He was discharged after one month and seven days of hospital treatment. At the time of discharge a list was given to the mother which described

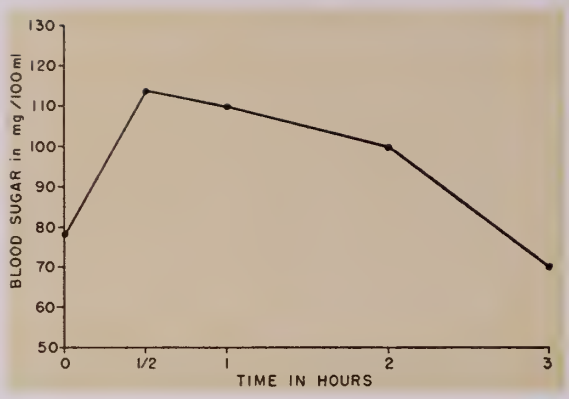


Figure 4. The glucose tolerance curve.

both gluten-containing and gluten-free food. The importance of a gluten-free diet was explained.

One month and nine days after his discharge from hospital, the child was re-examined. The size of his abdomen was markedly diminished and he had fat in both buttocks. He looked happy and could walk well. There was, however, no gain in weight. See Figure 2.

He lived far from the hospital and due to lack of cooperation, we were unable to follow him further. He died on February 14, 1960, in his home. The cause of death could not be determined.

Discussion

The age of onset, chief complaints, physical features and characteristics of the stools in this case, all point to the diagnosis of celiac disease. The slow rise in oral glucose tolerance test, the x-ray pattern of the small bowel and the beneficial effect of the gluten-free diet in this case support the above diagnosis.

The diagnosis of cystic fibrosis of the pancreas in this case can be excluded on the basis of normal sweat chloride test, absence of pulmonary abnormalities and presence of pancreatic enzymatic activity in the duodenal juice. The possibility of the diagnosis of lambliasis (giardiasis) also can be excluded by the absence of giardia cysts in the stools.

Several authors have reported the occurrence of this disease within the first few years, especially the first three years, of life[18, 20, 23, 24]. A number of investigators have called attention to the flat curve in the oral glucose tolerance test[2, 18, 25, 26]. Golden[27] first demonstrated clumping or flocculation of barium in contrast radiography of the small intestine in the celiac syndrome. Other investigators confirmed this finding in celiac disease[2, 11].

Summary

1. A case of celiac disease which responded to treatment with a gluten-free dietetic regimen is presented.

2. The graphical pattern of the oral glucose tolerance test and the x-ray pattern of the small bowel are illustrated.

3. The various points in favor of this diagnosis are also discussed.

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A Review of Epidermoid Carcinoma of the Penis*

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Treatment of choice in carcinoma of the penis, when feasible, is penectomy, followed as soon as possible by bilateral ilioinguinal lymphadenectomy. Epidermoid carcinoma of the penis is reviewed with respect to incidence, diagnosis and prognosis.

THIS report is based on a study of all the epidermoid carcinomas of the penis treated at the Louisville Veterans Administration and Louisville General Hospitals from January 1, 1948, to June 30, 1961. During this eighteen and a half year period, 40 patients with this disease were treated. While this case load is rather low, some interesting and definitive information is available with respect to the method of treatment.

Incidence

Epidermoid carcinoma of the penis constitutes approximately one to two per cent of all cancers in the male. In our series of 40, the ages ranged from 31 to 87 years. The highest incidence was in the fifth, sixth and seventh decades of life, and the average age was 57 years. Twenty-two of the 40 patients were white and 18 were Negro.

Etiology

Retention of smegma beneath the foreskin, leading to longstanding mechanical and chemical irritation of the skin and mucous membrane, is considered by many as an etiological factor. This retention can occur even if the individual is able to retract his foreskin. Chronic irritation of the glans and mucous membrane of the prepuce is a common finding in uncircumcised patients. It appears that almost complete prophylaxis against carcinoma of the penis is conferred by circumcision of the infant, but as demonstrated by four cases in our series, it is not assured by circumcision of the adult. Thirty-two of the 40 patients had never been circumcised, four had been circumcised in later life, and in four cases the information was not recorded. Twelve of the 40 patients had a phimosis, although the incidence was probably higher. Three patients had previously been treated for balanoposthitis.

Although syphilis and other venereal diseases are unproven as etiological factors, there is definitely a higher incidence of venereal disease in men with carcinoma of the penis than in the general population. Twelve of the 40 patients (30%) had either been treated for syphilis, and/or had a positive serologic test for syphilis.

Pathology

At an early stage, carcinoma of the penis appears either as a small, single, papillary or verrucous growth, or a flat, indurated lesion with or without ulceration (Figure 1). The



Figure 1: 15 mm. flat, ulcerated, superficially infiltrating epidermoid carcinoma of the glans penis.

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Figure 2: Infected, fungating epidermoid carcinoma involving the prepuce, glans and distal one-half of the penile shaft.

tumor usually begins on the glans, coronal sulcus or mucous membrane of the prepuce, and often is not recognized at an early stage because of an associated phimosis, or because the patient ignores the early symptoms produced by the cancer. The early stage loses its identity as the cancer invades both deeply and superficially. In the more advanced cases, the cancer usually presents as an ulcerated, infected, fungating lesion of varying sizes (Figure 2). In one of our cases, the neoplasm had completely destroyed the penis, and was invading the scrotum and pubic skin.

Buck's fascia, a fascial sheath derived from Colles' fascia, provides an effective barrier to invasion of the urethra and corpora cavernosa. In eight of the 40 cases, the carcinoma produced varying degrees of urethral obstruction, and in three cases, a urcthralcutaneous fistula was present. Although the corpora were invaded by cancer in several cases, there were only three instances of bloodborne metastases. These patients had pulmonary metastases, which were not evident on first admission (Figures 3a and b).

Fortunately, epidermoid carcinoma of the penis usually metastasizes relatively late in comparison to other carcinomas. Carcinomas of the prepuce and penile skin metastasize primarily to the superficial inguinal nodes, and carcinomas of the glans metastasize primarily to the deep inguinal and external iliac nodes. Lymphatics from the urethra communicate with those from the glans, and also drain into the deep inguinal, external and internal iliac nodes.[1]

At the time of their first admission, 16 patients had a small, superficial penile lesion,



Figure 3a: Chest x-ray with no evidence of metastases one year following partial penectomy.



Figures 3b: Chest x-ray of the same patient taken six months later demonstrates bilateral pulmonary metastases confirmed at postmortem examination six weeks later.

measuring two centimeters or less in diameter. Three of these 16 patients (19%) were found to have positive inguinal nodes as proven either by biopsy or lymphadenectomy. Twenty-two patients had a locally advanced penile cancer. Seven of these 22 patients (32%) had positive inguinal nodes as proven either by biopsy or lymphadenectomy. Overall, 10 of 38 patients (26%) had positive inguinal nodes. Preoperative excision biopsy of palpable inguinal nodes was performed in 11 cases, with positive nodes found in six instances. Aspiration biopsy was performed in one case with cell block studies positive for cancer. Three patients were found to have positive nodes following prophylactic lymphadenectomy. Most of the patients had palpable inguinal nodes on physical examination, and in three the presenting complaint was a mass in the groin in addition to the penile lesion. In two instances, the stage of cancer was not recorded, and none of the 40 patients had clinical or x-ray evidence of distant metastases at the time of their first admission.

Diagnosis

Table 1.

Signs and Symptoms	*No. Cases*
1. Painless growth or ulcer	20
2. Bleeding from lesion	12
3. Urethral obstruction	8
4. Painful growth or ulcer	6
5. Failure of circumcision to heal	3
6. Urethral-cutaneous fistula	3
7. Mass in groin	3
8. Recurrent growth on penile stump	2
9. Spontaneous amputation of penis	1
10. Comatose—terminal uremia	1

In this report, the duration of symptoms is the interval between the onset of symptoms and the diagnosis of epidermoid carcinoma of the penis. The duration of symptoms ranged from four days to ten years, with an average duration of 14 months. It is suspected that many patients underestimated the duration of their symptoms.

In 34 cases the clinical impression was confirmed by biopsy. The method of biopsy was by incision biopsy in 29 cases, excision biopsy in five cases, and in three cases the method was not recorded. Diagnosis was based on clinical appearance alone in three cases.

Treatment

The surgical procedures employed in the treatment of these cases are tabulated as follows:

Table 2.

		No. Cases
I. Total penectomy		13
A. Alone	5	
B. With lymphadenectomy	6	
C. With lymphadenectomy plus bilateral orchiectomy, excision of scrotum, bulbous urethrectomy and total perineal prostatectomy	1	
D. With bilateral orchiectomy and excision of scrotum	1	
II. Partial penectomy		24
A. Alone	14	
B. With lymphadenectomy	10	
III. Local excision		4
IV. Urinary diversion		5
A. Suprapubic cystostomy	4	
B. Vesicorectostomy	1	

The penis was amputated at an average of two and one-half centimeters proximal to visible and palpable tumor. Total penectomy and perineal urethrostomy were performed when sufficient penile stump could not be left to allow voiding without soiling the scrotum.

A total of 17 lymphadenectomies were performed. There were four unilateral and 13 bilateral inguinal lymph node dissections. In three of the 17 lymphadenectomies, the iliac as well as the superficial and deep inguinal nodes were removed. Five lymphadenectomies were performed for clinically positive nodes. There were a total of 12 prophylactic lymph node dissections, and positive nodes were recovered in three patients.

Local excision of the penile cancer was performed in four cases. The first patient died tumor-free 14 months following the excision of a two centimeter, Grade I cancer on the prepuce. The second patient died two years following the excision of a two centimeter, Grade I carcinoma on the coronal sulcus with no evidence of recurrence. The third and fourth patients were lost to follow-up.

Five patients received x-ray therapy. One patient received x-ray therapy to an extensive penile carcinoma, and two received x-ray therapy to regional metastatic lesions. All had operative procedures in addition to the radiation therapy. None of the lesions regressed, and all died of cancer of the penis. Two patients had small, superficial cancers (less than 2 centimeters in diameter) located on the glans with no evidence of regional metastases. One received 5600 r, and the other 3500 r. The first patient had a local recurrence seven years post-

treatment. A partial penectomy was performed, and he is now alive and tumor-free. The other patient died three and one-half years post-treatment with no evidence of recurrence.

Follow-Up

The duration of follow-up is measured from the definitive surgical procedure to either the patient's death or most recent follow-up examination (Table 3).

Table 3.

	0-1 Yr.	*1-5 Yrs.*	*5-13 Yrs.*
Penectomy Alone			
1. Alive and tumor-free	2	3	7
2. Alive with recurrence	0	0	0
3. Dead and tumor-free	1	2	0
4. Dead of Ca. of penis	1	1	0
5. Lost to follow-up	0	0	0
Penectomy & Prophylactic Lymphadenectomy			
1. Alive and tumor-free	0	1	7
2. Alive with recurrence	0	0	0
3. Dead and tumor-free	0	1	1
4. Dead of Ca. of penis	0	0	1
5. Lost to follow-up	1	0	0
Penectomy & Lymphadenectomy for Clinically Positive Nodes			
1. Alive and tumor-free	1	0	0
2. Alive with recurrence	0	0	0
3. Dead and tumor-free	0	0	1
4. Dead of Ca. of penis	0	3	0
5. Lost to follow-up	0	0	0
Local Excision			
1. Alive and tumor-free	0	1	0
2. Alive with recurrence	0	0	0
3. Dead and tumor-free	0	1	0
4. Dead of Ca. of penis	0	0	0
5. Lost to follow-up	2	0	0

The five-year survivals include those cases treated between January 1, 1948, and June 30, 1956. In determining the five-year survivals, we are assuming that those who are lost to follow-up died of carcinoma of the penis. If we excluded these cases, the five-year survival rate based on so small a series would, of necessity, represent a higher survival rate than we would consider valid for this disease entity.

1. *Penectomy Alone*

Total cases	11
No. alive at 5 years	7
Five-year survival	64%

2. *Penectomy & Prophylactic Lymphadenectomy*

Total cases	11
No. alive at 5 years	9
Five-year survival	82%

3. *Penectomy & Lymphadenectomy for Clinically Positive Nodes*

Total cases	3
No. alive at 5 years	1
Five-year survival	33%

4. *Overall Five-Year Survival*

Total cases	30
No. alive at 5 years	18
Five-year survival	60%

There were no five-year survivors of the three patients treated by local excision. One patient treated by x-ray survived five years, but had a local recurrence. Another patient admitted in terminal uremia died four days following suprapubic cystostomy.

Four of 11 patients (36%) followed 10 years or longer are alive and tumor-free.

Discussion

Because of the radioresistance of the majority of these tumors, most clinicians agree that radiotherapy is not the treatment of choice, and should not be employed unless the lesion is superficial, less than two centimeters in diameter, and there is no evidence of regional metastases. Edsmyr and Ekstrom[2] have treated the penile lesions with radiotherapy up to a tumor dose of 5000 r. They have followed six patients over five years. Four appear cured, and two have died. These same authors stated that local excision of small, superficial growths was satisfactory if they were located on the prepuce and not on the glans.

When partial penectomy was performed, the penis was amputated at an average of two and one-half centimeters proximal to visible and palpable tumor. There was only one instance of local recurrence following penectomy. A total penectomy and perineal urethrostomy were performed, and the patient is alive and tumor-free three and one-half years following the second operation. When the major portion of the penile shaft required amputation, in order to prevent soiling of the scrotum with urine, total penectomy and perineal urethrostomy were performed.

An analysis of our data revealed that 26% of 38 patients had regional lymph node metastases at the time of their first admission. Edsmyr and Ekstrom[2] evaluating 229 patients with carcinoma of the penis found metastases in 30% of the entire group. Staubitz, Lent and Ober-

kircher[3] in a series of 204 cases of carcinoma of the penis, found inguinal node metastases in 47% of their patients. With the above percentages in mind, and because of the difficulty in differentiating metastatic from infected lymph nodes, we feel that bilateral prophylactic groin dissection should be performed in every case of carcinoma of the penis unless the general condition or age of the patient does not permit. In this series, the five-year survival following penectomy and prophylactic lymphadenectomy is 82%, as compared to 33% following penectomy and lymphadenectomy for clinically positive nodes.

Rather than perform an en-bloc or one-stage penectomy and bilateral groin dissection, many investigators prefer to amputate the penis at the first operation, and wait a minimum of one to two weeks before doing the node dissection. Infection almost invariably follows dissection of an inflamed area; therefore, this interval allows the adenitis to subside, and also allows some of the tumor emboli within the intervening lymphatics at the time of penectomy to settle within the regional lymph nodes.

In three of 17 groin dissections, the iliac nodes were removed along with the inguinal nodes. Because carcinomas of the penis can metastasize primarily to the external iliac nodes, in our last three cases, we have performed a radical ilioinguinal lymphadenectomy as described by Gray and Bailey[4]. In 41% of the inguinal lymphadenectomies, small areas of sloughing of skin flaps occurred, requiring either pinch or split-thickness skin grafts. Also, in 41% of the groin dissections, mild to moderate postoperative lymphedema occurred, successfully treated in all cases by elastic stockings and/or periodic elevation of the lower extremities.

Summary

A review of patients with epidermoid carcinoma of the penis is reported. The incidence, etiology, pathology, diagnosis and treatment are discussed. The over-all five-year survival of 30 patients is 60%. The five-year survival for penectomy alone is 64%; for penectomy and prophylactic lymphadenectomy, 82%; and for penectomy and lymphadenectomy for clinically positive nodes, 33%. The authors feel that penectomy followed in one or two weeks by bilateral ilioinguinal lymphadenectomy is the treatment of choice for carcinoma of the penis unless the age or general condition of the patient does not permit.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Adult Hirschprung's Disease

William H. Marshall, M.D., and Joseph E. Kutz, M.D.*

Case Presentation

V. W., a 24-year-old married woman, was admitted to Louisville General Hospital on May 21, 1962, with a chief complaint of "bowel troubles all of my life." She had had constipation and abdominal distention since early infancy, and was given daily enemas by her mother until age 10 years. Symptoms had progressed and she would go for periods of two to three weeks without bowel function. The patient said she drank three to six ounces of castor oil and/or a half-pint of milk of magnesia daily; however, bowel function would occur only when she gave herself enemas every two to three days. The stool was hard and accompanied by bright red rectal bleeding.

Abdominal distention and lower abdominal cramps occurred between bowel movements, being relieved only by passage of flatus or bowel function following enemas. The patient was never incontinent of feces. Her general health was good and she maintained her weight at 110 pounds.

There was no family history of megacolon or other congenital disease. The past medical history was not significant.

Physical examination showed a healthy thin white female in no acute distress. The temperature, pulse and respiration were normal. Poor oral hygiene was noted. The general physical examination was otherwise unremarkable, except for the abdomen, which was protuberant and asymmetrical with the greatest distention on the left side. A large cylindrical mass, apparently the colon, was moderately tender and could be moulded like clay through the abdominal wall. Bowel sounds were normal. Rectal examination revealed good anal sphincter tone with a large fecal mass palpable at the finger tip above an empty lower rectal segment.

The hemocrit was 40%. The urinalysis and blood chemistries were within normal limits. A chest film was interpreted as being normal.

Discussion

This case is presented as a problem of megacolon in a young adult requiring a differential diagnosis of cause before the initiation of specific treatment. There are several different classifications of megacolon. One of the most reasonable is outlined by Gardiner[1] and is modified as follows:

Classification of Megacolon

A. Obstruction
   1. Congenital stricture
   2. Operative or traumatic stricture
   3. Stricture due to lymphopathia venereum
   4. Neoplastic obstruction
B. Congenital
   1. Aganglionic (Hirschprung's disease)
C. Simple
   1. Due to congenital elongation and redundancy of sigmoid associated with chronic or acute volvulus
   2. Psychogenic or habit constipation
   3. Bulky cellulose diets (found in eastern Europe)
   4. Atony of the bowel in old age
   5. Repeated attacks of volvulus
   6. Secondary to infection with Trypanosoma cruzi (Chagas' disease)

In considering a differential diagnosis on the present patient, physical examination was sufficient to rule out obstruction as a cause of the megacolon. Similarly, the patient's age excluded consideration of the megacolon fre-

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quently found in geriatric patients. However, the differential diagnosis between a true congenital aganglionic megacolon and an acquired (or habit) psychogenic megacolon is not nearly so simple and is the common problem when young adults present the symptom of megacolon.

The history and physical examination are of prime importance in differentiating between congenital and acquired megacolon. Congenital megacolon almost invariably gives a history of constipation requiring enemas in neonatal life, and although the severity of the constipation may vary, it dates back to the neonatal period.

Habit Megacolon

The patient with acquired or habit megacolon develops symptoms later in life, frequently during the period of toilet training. A patient with congenital megacolon has a small, hard stool in contrast to the habit constipation patient with huge, large-diameter stools which have been reported to block toilet facilities. Fecal incontinence and soiling is common in habit constipation and almost never present in the true congenital megacolon. Upon inspection of the anus, a dirty, soiled, sometimes fissured anus is found in habit constipation, contrasted to a clean, normal anus in congenital megacolon. Digital examination reveals the rectal ampulla to be filled with feces in the habit-constipated, while a narrow, empty rectal segment occurs in the aganglionic megacolon.

Riker[2], however, points out that stool may be found in the rectal ampulla if the diseased segment is short. Examination of the abdomen in Hirschprung's disease reveals moderate to marked distention, a large fecal-filled colon which can frequently be palpated, and peristaltic waves associated with rushes. The older patient with congenital megacolon frequently shows retardation of growth. In contrast, the habit-constipated patient usually shows normal development, without significant abdominal distention and without peristaltic waves or rushes.

With the points of differential diagnosis in mind, a review of the history and physical examination leads to a fairly secure diagnosis of congenital megacolon in this patient. Further aid was obtained from x-ray findings which were characteristic of congenital megacolon. The most notable of these was the demonstration by barium enema of a narrow rectum and lower sigmoid colon with a markedly distended, fecal-filled colon above the narrowed segment. On flat plate and upright films of the abdomen, this distended colon with feces and air-fluid levels was also demonstrated.

"Sine Qua Non" of Diagnosis

The 'sine qua non' of the diagnosis, however, rests on the pathological demonstration of the absence of ganglion cells in Auerbach's plexus and herein rests the basis of the cause and treatment of this disease.

Hirschprung, whose name the disease carries, first demonstrated the ganglion deficiency in the non-dilated portion of the distal bowel in the year 1888[3]. His findings were confirmed by many subsequent authors and it was gradually realized that the normal-appearing, but nerve cell-deficient, bowel did not exhibit peristaltic action and hence served as a functional obstruction to the fecal stream. The dilation, muscular hypertrophy, and hyperperistaltic action of the colon proximal to the neuro-muscular deficient segment is merely a normal colon reacting to a functional obstruction just as if the obstruction were caused by stricture or tumor.

Swenson[4] receives the credit for correlating these facts and devising the sufficient treatment which consists simply of removing the obstruction. This is done by excising the neuro-muscular deficient, but normal-appearing, segment and pulling the normal, but distended bowel down for a low anal anastomosis.

Aganglionic Segment

The aganglionic segment invariably starts at the dentate line and extends for a variable distance proximal. At times this can involve the entire colon, but most frequently the aganglionic segment terminates in the sigmoid or left colon. It is essential that the excision be carried low, as only a few centimeters of diseased bowel remaining in place can cause continued symptoms in the postoperative period resulting in a failure of surgery.

Due to the fact that Hirschprung's disease is congenital and usually manifests itself in infancy, the diagnosis and treatment is usually carried out in the pediatric patient. However, the less severe forms of the disease are not incompatible with life and the patient may go several years before diagnosis is made or treatment instituted. The literature contains many case reports of congenital megacolon first diag-

nosed and treated in adolescent or young adults. However, in the past 10 years, there have been only two reports of congenital aganglionic megacolon in patients over 50 years of age. One of these was a 64-year-old woman who herniated her huge megacolon into the pleural cavity, perforated and developed a fecal pleural fistula and subsequently died. At autopsy an area of aganglionosis extended from the dentate line into the lower sigmoid colon.[5] The second case reported concerned a physician who knew his diagnosis and had worked out a 'satisfactory' regime for bowel function. This consisted of taking enemas of a gallon of water every three to four days, rolling about on the floor and massaging the abdomen, after which he was able to effect bowel function by manually pressing on his abdomen. In this manner, he was able to carry on the active practice of medicine.[6]

Understanding the clinical characteristics of the disease and the pathophysiology, the treatment of this case was undertaken with strong clinical and radiological suspicion of congenital megacolon. It was felt necessary, however, to prove the diagnosis by a trans-rectal biopsy of the muscle of the rectal wall prior to performing a laparotomy.

This was done, as described by Swenson, under general anesthesia on May 28, 1962, in the lithotomy position. Frozen section demonstration of ganglion cell absence confirmed the clinical diagnosis. In the pediatric patient, it is sometimes possible to perform the definitive operation as a primary procedure. The marked dilation and hypertrophy of the proximal colon in this patient indicated the performance of a staged procedure, the first stage being a colostomy above the aganglionic segment. This would allow the dilated proximal colon to return to normal size and facilitate the subsequent pull-through procedures.

After receiving confirmation of the diagnosis, the abdomen was prepared and entered through a left para-median incision. A huge dilated transverse and left colon was demonstrated which narrowed abruptly to normal caliber in the lower sigmoid area. A biopsy of the muscle wall was taken immediately above the site of the narrowing. This was interpreted as showing ganglion cells which were abnormal in character and deficient in number. Since it is important to make the colostomy in normal colon in order to overcome the functional obstruction, a third biopsy was taken from higher up in the lower descending colon. This specimen showed normal ganglion cells on frozen section. A left colon colostomy was established at this point, and the abdomen closed.

The patient did well following the procedure, and early in the postoperative course established normal colostomy function with daily movements. She was discharged home to allow time for the dilated, hypertrophied colon to return to normal size before the definitive procedure was performed.

The patient was readmitted six weeks after the colostomy. X-ray examination of the colon proximal and distal to the colostomy showed it to be of normal caliber. After the usual mechanical and antibiotic bowel preparation, she was taken to surgery on July 25, 1962. Utilizing an abdominal approach, the diseased recto-sigmoid segment was mobilized and everted through the anal sphincter, onto the perineum where it was amputated. The proximal normal colon was then telescoped through the rectal segment and anastomosed to the rectal stump from a perineal approach. The completed anastomosis was then allowed to retract above the anal sphincter.

The patient did well postoperatively, began having spontaneous bowel function on the fourth day after surgery, and continued to do so with a frequency of about two times daily throughout the remainder of her hospitalization. Digital exam revealed a low anastomosis two centimeters from the mucocutaneous line, rectal sphincter tone was good and she had no difficulty with fecal incontinence. Infection of the abdominal wound prolonged her hospital stay, and she was discharged on August 25, 1962.

She continues to do well at the present time, with one to two formed stools daily. She takes no cathartics or enemas and has no difficulty with fecal incontinence.

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EDITORIALS

Where Do We Go From Here ?

THE NOVEMBER election provided little upon which a forecast for the future may be made relative to the prospect of passage of the medical care through Social Security legislation—defeated by so narrow a margin in the last Senate. No one can predict what will be the temper of the next Congress on this matter. Some staunch friends and reliable advocates of the American Medical Association's philosophy were defeated for reelection, others were retained or newly elected. If one were to estimate the attitude of the next Congress it would most probably be favorable to the Federal Administration.

Marquis Childs in his November 14 summary on "How White House Views November 6 Vote" states that the first of the three or four vital measures upon which early action will be taken is medical care for the aged under Social Security. He opines that the President's political advisers believe that the AMA's educational campaign respecting this issue fell flat and that with the addition of some liberals in congress the "centers of resistance" which blocked the legislation last summer can be overridden.

This estimate may be reasonably accurate, but other viewpoints are to be considered. Edward Annis, M.D., recently called attention to a Gallup poll taken eight months ago in which 67% of expressed opinion favored medical care through Social Security. A later poll by Gallup showed that this percentage had reduced to 55% and in a very recent Gallup poll only 44% favored it. This is in accord with preelection observations in various parts of the country as recorded by Samuel Lubell. The better informed people became regarding the character of and manner of financing medical care, its actual limitations and inequities, the smaller became the percentage of voters who favored such a measure.

Doctor Annis feels that a well-informed public will increasingly oppose the medical care for the aging in the form presently proposed in Congress. Actual provisions of the measure are poorly understood. There is an increasing appreciation of the unfairness of providing medical care at government expense and under government control for millions of Americans well able to provide their own. Total medical care is not provided as so many needy older people now believe. The tax burden cannot but increase as the plan grows. He pointed out that only about 12.5% of the cost of Britain's Medical Care program is covered by the financing plan set up to cover it. The rest is borne by general taxation.

We think that the presently proposed medical care for the aged through Social Security is a bad thing and the following national organizations endorse our position:

American Farm Bureau Federation
Chamber of Commerce of the United States
Council of State Chambers of Commerce
Health Insurance Association of America
Junior Chamber of Commerce of the United States
National Association of Life Underwriters
National Association of Manufacturers
National Retail Merchants Association
National Small Business Men's Association

There are and will be many others for us if our program of public information continues with vigor.

It seems certain that the efforts of our AMA must be widened and intensified with the greatest speed and concentration if we are to succeed. Education of the people—our friends and acquaintances, luncheon and civic clubs, church groups, wherever we may speak—has so far been effective. But we cannot relax if we are to win.

Sam A. Overstreet, M.D.

The SMA

THE SOUTHERN Medical Association convened in November at Miami Beach, Fla., for its 56th annual meeting. Three thousand physicians attended from the 17 southern states from which the membership of the SMA is derived. Seventy-two Kentucky physicians were there to enjoy the scientific and social features presented, and to honor our own A. Clayton McCarty, M.D., retiring president—not that Clayton is so retiring; he presided at this meeting and at the final gala dinner relinquished his office to Daniel L. Sexton, M.D., an internist of St. Louis, Mo.

The Southern has a membership of about 16,000, representing all phases and specialties in medicine, next largest in the character of its membership to the AMA. The composition and quality of the scientific programs and exhibits are quite similar. There is an intimacy and a social atmosphere, however, not usually found at the larger meeting. It furnishes a fine alternate opportunity for the physician and his wife unable to attend the AMA, and meets at a season always delightful in the southern section of the country.

There are more than 700 Kentucky members of the SMA—and at that we are less well represented than most of the southern states. During the past 30 years there have been five Kentuckians elected to the presidency—Irvin Abell, M.D.; A. T. McCormick, M.D.; Elmer L. Henderson, M.D.; James A. Ryan, M.D., and A. Clayton McCarty, M.D. These men contributed a great deal toward the present excellent quality of the organization. The meeting this year seemed particularly good, especially for the character of the scientific sessions and attendance.

Thirty-one medical schools are in the southern states. During the past five years the SMA has encouraged attendance of medical students and has invited as its guests one senior class representative from many of the southern schools. A fine selection of 21 senior students representing as many medical schools were our guests. Next year all 31 schools will be invited to send one elected representative to the meeting at New Orleans. This has proved a stimulating feature.

Get interested in the Southern!

Sam A. Overstreet, M.D.

A Time to Look Back; A Time to Look Ahead; A Time to Say Thank You!

DECEMBER and the Holiday season and this December issue of The Journal provide a moment to look back and also to look ahead.

It is a time to express appreciation to our editors, consultants, the contributors, the members of the Advisory Committee to the Editor, our advertisers, and our readers. It is a time to reckon how far we have come and a time to make plans for the coming year.

First, may we say a big "thank you" to our editors who devote much time and effort to making this one of the better state medical journals For instance, the Editor and his Associate are in the KSMA Headquarters Office almost every Monday morning at 7:30 to give direction to the development of The Journal.

To our consultants who work anonymously we say "thank you" for all the time that you spend in reviewing and evaluating the scientific material so that The Journal can present the best possible medical literature for our readers.

"Thank you" to our many fine contributors who work long hours writing scientific papers, editorials, and other material to keep our Journal readers up to date on the latest developments in scientific, political, and social areas.

We will not forget the members of the Advisory Committee to the Editor. We would like to express our appreciation for their thoughtfulness, for their interest, advice, and assistance.

We offer a special "thank you" to our Journal advertisers, whose contributions in our advertising columns are informative and timely, and whose patronage has contributed so substantially to the success of our Journal.

We, the lay members of the staff of The Journal of KSMA, are proud to be associated with our dedicated family of editors, consultants, advisors, advertisers, and our readers.

The production of a journal such as ours in which approximately 60 uncompensated hours of physicians' time are contributed in each issue is obviously a team effort. As in any other team, the degree of performance develops to a large part on the direction it gets. Our "team" is blessed with excellent leadership.

Looking ahead to 1963, it can be said that the Editor and his associates are working on a number of plans that are designed to make our Journal more attractive and useful to all our readers and KSMA members. Your constructive suggestions are welcomed.



We Wish You

A Very Pleasant

Holiday Season

Sam A. Overstreet, M.D., Editor
and
The Journal Staff

The Lyman Beecher Todd Memorial Meeting of The Kentucky State Medical Association

Roof Garden, Brown Hotel, Louisville, Kentucky, September 17-19, 1962

Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Sam A. Overstreet, M.D., Louisville

Speaker of the House, Presiding

First Session

After a very informative talk by D. W. Penner, M.D., of Winnipeg, Manitoba, Canada, Doctor Overstreet called the meeting to order and asked for a report from the Credentials Committee. Harold Barton, M.D., chairman of this committee, reported that a quorum was present. It was moved and seconded that minutes of the 1961 meeting be accepted as published in The Journal, and the motion carried.

Woodford B. Troutman, M.D., KSMA secretary, announced that the one hundred and twelfth Annual Meeting would get underway the next day and he urged everyone to attend the scientific sessions and the President's Luncheon. He also stated that on Wednesday there would be a Transatlantic CPC on Renal Diseases. Cases would be presented by a group from KSMA and internationally known physicians from Glasgow, Scotland. The reference committees would hold their hearings starting at 2 o'clock Tuesday afternoon.

At the conclusion of the announcements, Doctor Troutman read the list of the physicians who had passed away since the 1961 meeting, and the House stood for a moment of silence to pay tribute to them. The names of the physicians, their locations and dates of death are as follows:

Adkins, Paul W., Pineville, March, 1962
Andreasen, Alfred W., (Member), Danville, February, 1962
Barr, Joseph L., (Emeritus), Frankfort, July, 1962
Bates, David A., Okolona, September 10, 1961
Bloch, Leo, (Emeritus), Louisville, November, 1961
Boggs, J. P., Louisville, April, 1962
Brosheer, C. K., (Emeritus), Middlesboro, June 23, 1962
Brownstein, S. J., (Emeritus), Louisville, October, 1961
Bryson, Andrew J., (Emeritus), Ashland, June 24, 1962
Callis, William A. Scottsville, September, 1961
Carr, Arch M. Jr., Middlesboro, November, 1961
Crutcher, L. A., (Emeritus), Louisville, June, 1962
DeWeese, Clarence (Member), Lexington, August, 1962
Donnelly, Arthur D., (Emeritus), Bowling Green, September, 1961
Dunn, James H., Lexington, February 16, 1962
Elliott, Richard G., (Member), Lexington, February, 1962
Erkeletian, D. H., (Member), Hopkinsville, August, 1962
Finley, Austin, (Member), Madisonville, August 18, 1962
Foertmeyer, Wm. A., (Member), Bellevue, 1962
Foshee, Henry G., Lexington, October 25, 1961
Fuller, Wm. H., (Member), Mayfield, January, 1962
Ginn, Tolbert B., (Emeritus), Vanceburg, January 9, 1962
Glaboff, J. J., (Member), Louisville, May, 1962
Goldsborough, R. M., (Emeritus), Louisville, August, 1962
Goodman, T. D., (Emeritus), Ashland, April 17, 1962
Gowdy, Edwin L., (Emeritus), Campbellsville, March 13, 1962
Grant, W. C., Winchester, December, 1961
Hainline, Samuel E., (Emeritus), Winchester, November, 1961
Hale, Lonnie D., (Emeritus), Murray, October, 1961
Harvey, R. Henry, Winchester, December 9, 1961
Heistand, C. V., (Emeritus), Campbellsville, January, 1962
Holbrook, Raymond N., Louisville, July, 1962
Hunt, Josephine, (Emeritus), Lexington, February, 1962
Jefferson, W. H., (Emeritus), Lexington, September, 1962
Jenkins, J. Emery, (Member), Sebree, June 23, 1962
Jett, Nelson A., Florence, August, 1961
Keith, W. N., Paintsville, March 31, 1962
McIlvain, Edgar S., Cynthiana, July, 1962
Marshall, Thomas J., (Member), Paducah, August 7, 1962
Morse, William L., Earlington, October 17, 1961
Mullins, Stanley, (Emeritus), Wingo, March, 1962
Nelson, Harry, Ft. Thomas, March, 1962
Nusz, H. A., Elizabethtown, April, 1962
Oates, Lewis A., Madisonville, June, 1962
Paris, Samuel E., (Member), Bowling Green, May, 1962
Pigman, Owen, (Member), Whitesburg, February, 1962
Rau, Ernest, Bowling Green, May 25, 1962
Reardon, Marc J., (Member), Covington, February 18, 1962
Rees, John M., Cynthiana, July, 1962
Reynolds, Oliver M., Louisville, January 4, 1962
Richey, Leslie, (Emeritus), Park City, December, 1961.
Richie, S. M., Hazard, October, 1961

Russell, Harvey, Winchester, December 9, 1961
Sauter, Leo C., (Member), Newport, January, 1962
Schnake, E. R., Newport, August, 1962
Simpson, Lloyd, (Member) Paducah, November, 1961
Smith, U. H., Louisville, June 14, 1962
Tucker, J. C., (Member), Leitchfield, September 2, 1962
Townsend, John M., (Member), Louisville, April 9, 1962
Vance, C. A., (Emeritus), Lexington, August 2, 1962
Walter, William J., (Emeritus), Pikeville, March, 1962
Whistler, Edw. P., Harrodsburg, May, 1962
White, George H., (Emeritus), Castlewood, October, 1961
Wicker, Melvin V., (Member), Hindman, April, 1962
Williams, J. D., Ashland, September, 1961
Winter H. B., Murray, July, 1962

The Speaker then announced the reference committee appointments, subject to the approval of the House of Delegates as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees
W. R. Byrne, M.D., Russellville, Chairman
Ballard Cassady, M.D., Pikeville
Eugene L. Marion, M. D., Glasgow
T. N. Perry, M.D., Jenkins
George H. Widener, M.D., Paducah

Reference Committee No. 2—Scientific Assembly and Medical Education
Guinn S. Cost, M.D., Hopkinsville, Chairman
Ralph Denham, M.D., Louisville
K. M. Eblen, M.D., Henderson
Thomas McElhinney, M.D., Covington
Loman C. Trover, M.D., Madisonville

Reference Committee No. 3—Legislative Activities
Melvin Bernhard, M.D., Louisville, Chairman
Thornton Bryan, M.D., Cadiz
Lenore P. Chipman, M.D., Williamstown
E. C. Seeley, M.D., London
Robert L. Shuffett, M.D., Greensburg

Reference Committee No. 4—Public Service and Allied Professions
Harvey Chenault, M.D., Lexington, Chairman
Richard A. Allnutt, M.D., Covington
James W. Archer, M.D., Paintsville
Charles F. Long, M.D., Elizabethtown
Earl P. Oliver, M.D., Scottsville

Reference Committee No. 5—Medical Service
B. F. Radmacher, M.D., Louisville, Chairman
R. Ward Bushart, M.D., Fulton
Salem M. George, M.D., Lebanon
David M. Greeley, M.D. Harlan
Harold Keen, M.D., Bowling Green
E. C. Strode, M.D., Lexington

Reference Committee No. 6—Constitution and Bylaws; Special Committees
C. J. Shipp, M.D., Greenville, Chairman
Austin Bloch, M.D., Louisville
M. Randolph Gilliam, M.D., Lexington
R. L. Houston, M. D., Eminence
William Woolfolk, M.D., Owensboro

Reference Committee No. 7—Miscellaneous
James Ramsey, M.D., Frankfort, Chairman
Donald Chatham, M.D., Shelbyville
J. M. Hunt, M.D., Wickliffe
James Riley, M.D., Louisville
J. H. Saunders, M.D., Lexington

Motion was made and seconded that the reference committee appointments be approved. Motion carried.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of Speaker of House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1

William H. Bizot, M.D., presented the report of the Awards Committee, of which he was chairman. These were the nominations of that committee:

Distinguished Service Award — Mitchel Denham, M.D., Maysville

Outstanding General Practitioner Award—John P. Walton, M.D., Central City

It was moved and seconded that the nominations be closed and that the secretary cast one ballot for Doctors Denham and Walton.

Other reports were received and referred as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of Executive Secretary—Reference Committee No. 1

Council on Scientific Assembly—Reference Committee No. 2

Council on Medical Education and Hospitals—Reference Committee No. 2

Council on Legislative Activities, Parts I and II—Reference Committee No. 3

Council on Medical Services—Reference Committee No. 5

Council on Communications and Public Service—Reference Committee No. 4

Council on Allied Professions and Related Groups—Reference Committee No. 4

Advisory Committee to the Editor—Reference Committee No. 6

Professional Relations Committee—Reference Committee No. 6

Committee on Third Party Medicine—Reference Committee No. 6

Committee to Study the Constitution and Bylaws—Reference Committee No. 6

Interim Meeting Committee—Reference Committee No. 6

KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7

KSMA Representative, U. of K. Chapter, Student AMA—Reference Committee No. 7

KSMA Representative, U. of L. Chapter, Student AMA—Reference Committee No. 7

KSMA Representative on Kentucky Poison Control Program—Reference Committee No. 6

KSMA Representative on State TB Coordinating Council—Reference Committee No. 4

McDowell Home Committee—Reference Committee No. 7

Medicolegal Administrator—Reference Committee No. 7

Building Committee—Reference Committee No. 7

Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 5

Board of Trustees, Rural Kentucky Medical Scholarship Fund—Reference Committee No. 5

Advisory Committee to Selective Service—Reference Committee No. 5

Report of Woman's Auxiliary—Reference Committee No. 7

Representative, Advisory Committee on Maternal and Child Health, State Department of Health—Reference Committee No. 7

Kentucky Health Council — Reference Committee No. 4

Memorials Commission—Reference Committee No. 7

Technical Advisory Committee on Indigent Medical Care—Reference Committee No. 5

New Business

The new business was then presented to the House and referred to reference committees by the Speaker as follows:

(A) Resolution of the Muhlenberg County Medical Society concerning AMA Social Security action—Reference Committee No. 3.

(B) Resolution of Muhlenberg County Medical Society on the subject of commending KSMA Legislative Council, Officers and Trustees—Reference Committee No. 3.

(C) Resolution of KSMA Board of Trustees concerning appreciation for AMA leadership—Reference Committee No. 3.

(D) Resolution of Kentucky Society of Pathologists on the subject of practice of medicine in laboratories—Reference Committee No. 5.

(E) Resolution of Highway Safety Committee on the subject of automotive safety—Reference Committee No. 4.

(F) Resolution of School Health Committee concerning physical education—Reference Committee No. 4.

(G) Resolution of Campbell-Kenton County Medical Society on cultist education—Reference Committee No. 2.

(H) Resolution of Campbell-Kenton County Medical Society concerning postgraduate medical education —Reference Committee No. 2.

(I) Resolution of Campbell-Kenton County Medical Society on reapportionment of trustees—Reference Committee No. 1.

(J) Resolution of Fayette County Medical Society on invitation to Kentucky State Medical Association to Lexington in 1963—Reference Committee No. 1.

(K) Resolution of Fayette County Medical Society concerning appreciation of the Woman's Auxiliary—Reference Committee No. 7.

(L) Resolution of Jefferson County Medical Society on the subject of commendation and appreciation for editors of KSMA Journal—Reference Committee No. 1.

(M) Resolution of James B. Douglas. M.D., on the subject of exclusion of medical services from the coverage included in the National Blue Cross Plan for the Aged—Reference Committee No. 5.

(N) Resolution from Pike County concerning Kerr-Mills program—Reference Committee No. 5.

(O) Resolution of Warren County Medical Society on the subject of adjustments in the Kerr-Mills program—Reference Committee No. 5.

(P) Resolution from Harlan County on the subject of compulsory seat belt usage—Reference Committee No. 4.

The meeting places for the Nominating Committee for general officers and the five Trustee Districts were announced by the Speaker. He stated that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning in the Columbia Auditorium, and that on Wednesday night at the second meeting of the House, these nominations would again be read, and, according to the Bylaws, additional nominations could be made from the floor without discussion or comment.

With there being no further business the meeting adjourned at 10:32 p.m.

Second Session

The second session of the House of Delegates was called to order on September 19, 1962, by Speaker Sam A. Overstreet, M.D. Wyatt Norvell, M.D., gave the invocation. Harold Barton, M.D., reported that a quorum was present.

Lillian H. South, M.D., was recognized and announced that the Order of Kentucky Colonels were giving $1,000 to train laboratory technicians and also would lend microscopes to medical students to use during the period of time they were in medical school. After this presentation, it was moved and seconded to express appreciation for this gift and the motion carried.

Doctor Overstreet then announced the tellers for the meeting as follows:

Sam D. Weakley, M.D., Chairman, Louisville
Charles Bisig, M.D., Louisville
A. L. Embry, M.D., Millwood
L. E. Hurt, M.D., Lexington
John Hemmer, M.D., Louisville
Charles Stacy, M.D., Pineville

It was explained that the purpose of this was to insure proper voting procedures.

The Chairman of the Board of Trustees, Wyatt Norvell, M.D., presented the final report of the Board as follows:

"The Board submits the following resolution, passed at its September 19 meeting:

"WHEREAS, the 1962 KSMA Annual Meeting has made a substantial contribution in the field of continuing medical education and has been well received, and

"WHEREAS, many individuals, organizations, and agencies including guests and state essayists, scientific and technical exhibitors, newspapers, radio and television stations, hotels, and the Auditorium, have contributed to its success, and

"WHEREAS, the Transatlantic CPC sponsored by Smith, Kline and French has made a substantial contribution to our meeting, now

"THEREFORE BE IT RESOLVED that this House of Delegates goes on record as expressing its deepest appreciation to all individuals and organizations who have had a part in the development and implementation of the 1962 Annual Meeting."

It was taken by consent that this be accepted.

The reports of the Reference Committees were then presented.

REFERENCE COMMITTEE NO. 1

W. R. Byrne, M.D., Chairman
Report of Officers and Board of Trustees

Report of the President

It is probably obvious to you that the duties of the president of the Kentucky State Medical Association are more time consuming and demanding each year. Those duties which relate to the scientific affairs of our organization are no more complex, but certain extra-professional factors, particularly the legislative program during the past two or three years, have demanded a great deal of attention. The reorganization of the committee and council structures of KSMA two or three years ago, consonant with that of the AMA, streamlined to an appreciable degree the mechanics of conducting the many and varied activities of the Association.

Most of the efforts of the retiring president during the past year have been directed toward implementation of an acceptable legislative program. With this in mind, a Steering Committee composed of the President-Elect, Chairman of the Trustees KSMA, Chairman of the State and Federal Legislative Councils, and the President of KSMA, held a number of conferences during the latter months of 1961 for the purpose of planning a program presenting information to our members, relative to legislation pertinent to our interests. The efforts of this group were fruitful, and during the months of January and February 1962, each of the 15 KSMA Trustees held meetings before which members of a Speakers' Bureau appeared and discussed the question of Medical Care to Kentucky's Indigent from four standponts, namely:

1) The Social Security Law, its present economic status, undesirable features, etc.

2) The Kerr-Mills Law and its potential.

3) The proposed King-Anderson legislation, and

4) A means of acquainting Kentucky's Congressmen with our feelings concerning a compulsory medical care program in the Department of Social Security.

The date of the Interim Meeting of KSMA was advanced to February 22 and the program was oriented in this direction also. There was also a determined effort to emphasize the importance of physician and auxiliary participation in community and precinct politics at a "grass-root" level throughout the state.

The relative success of these endeavors was made possible by the gratifying cooperation of the Trustees of KSMA, the very ably directed Legislative Council both state and national, and participation of many individual physicians who comprised the Speakers Bureau, County Society officers, and other groups and individuals.

The Councils and Committees of KSMA have been quite active this year and their accomplishments have been most impressive. I owe a debt of gratitude to the Trustees, Council and Committee members, especially the Building Committee, and to all others who have so willingly contributed to the 1961-62 KSMA activities.

For two or more years now I have had the pleasure and the opportunity of meeting the secretarial staffs from many of the 50 State Medical Associations, and I can truthfully say that I know of no group who have been more effective, more loyal, and more devoted to their duties than the headquarters staff at KSMA. I hope that every member of this organization is thoroughly aware of the great volume of work that they do under the very effective direction of Joseph P. Sanford.

This organization reached a milestone during the calendar year of 1961 when it occupied its own home; the first in its long history. Although this has been an appreciable investment for us, it is my personal feeling, and that of many others, that the investment was entirely reasonable, and that the benefits will accrue to us in the form of more efficient operation of our various programs which will far outweigh the investment.

I shall list for you in chronological order, but will not read, the various activities in which I participated as President of your Association. I attended all the Trustee and Executive Committee meetings during the year and was fortunate in having able representation from the President-elect, D. M. Cox, M.D., and the three Vice Presidents, on certain occasions when it was impossible for me to attend out-of-state meetings. Doctor Cox attended the Tennessee State Association's meeting and represented KSMA at the Annual Meeting of the KAGP. Henry Asman, M.D., represented KSMA at the Southern Surgical Congress in Louisville in April, and at the Illinois State Association's meeting in May.

I attended and participated in the following activities:

October, 1961, Blue Shield Conference in Chicago.

October 25-26, 1961, the Indiana State Medical Association meeting in Indianapolis.

November 2, 1961, the Rural Health Conference at Kentucky Lake.

November 5, 1961, a discussion of King-Anderson type legislation before the Jefferson County Medical Assistants organization at the Kentucky Hotel.

November 25, 1961, AMA's Interim Meeting in Denver, Colo.

January, 1962, Muhlenberg County Farm Bureau, Greenville.

January 6, 1962, Specialty Group KSMA Presidents, Louisville.

January, 1962, Business & Professional Woman's Club, Greenville.

January, 1962, participated in four of the 15 KSMA Trustee District meetings:

First Trustee District, Kentucky Lake.

Third Trustee District, Hopkinsville.

Fifth Trustee District, Louisville.

Sixth Trustee District, Bowling Green.

January 9, 1962, American Association of University Women in Owensboro.

February, 1962, Muhlenberg Community Hospital Credit Union, Greenville.

February 22, 1962, KSMA Interim Meeting, Owensboro.

March 13, 1962, Presided at the Congressional Dinner in Washington, D.C.

March 19, 1962, Addressed the University of Louisville Medical School Senior Class in the Rankin Amphitheater.

March 19, 1962, attended the meeting of the Kentucky Pharmaceutical Association in Lexington and heard John R. Seele, a British physician, talk about the British Health Organization.

March 21, 1962, Represented KSMA at the KHA Annual Meeting in Louisville.

March 28, 1962, I presented an award to six elderly physicians at Owensboro for the Daviess County Medical Society.

May 16, 17, 18, 1962, I attended the Ohio State Medical Association's Annual Meeting in Columbus.

May 20, 1962, I participated in the dedication of the KSMA's new office building.

Week of June 24, 1962, I attended the Annual AMA session in Chicago.

July 23, 1962, represented KSMA at the Kentucky Pharmaceutical Association's Annual Meeting in Paducah.

G. L. Simpson, M.D., Greenville
President

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends acceptance of this report and wishes to compliment the President for the excellent job which he has done.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the President-Elect

This year of indoctrination has been pleasant and instructive. My contacts have shown me that Kentucky has many fine doctors who are serving their communities as reliable physicians and as good citizens.

Officially, I have served on the Program Committee. However, I attended several meetings of other committees.

Doctor Simpson asked me to serve on the Speakers Group which talked in every Trustee District about: (1) Social Security, (2) Kerr-Mills Law, (3) King-Anderson Bill, and (4) what we can do about it. It was my privilege to talk in three areas. All of those who participated learned a lot and, I am sure, are more dedicated to the free practice of medicine than they were a year ago.

I attended the AMA House of Delegates at Denver and Chicago and, in each case, was not able to attend the scientific meetings. In January I also attended an AMPAC and anti-HR 4222 day-long meeting in Chicago that was most inspirational.

Doctor Simpson asked me to represent him and the KSMA in Memphis for the Tennessee Medical Association Annual Meeting and to talk to the Sixth Trustee District at Russellville on "Long Term Chronic Illnesses."

At the Interim Meeting in Owensboro, it was my privilege to preside during the afternoon meeting.

Representing KSMA, I talked on "Highway Safety" to the Louisville Eye and Ear Society. Then I talked on Social Legislation to the Medical Assistants, Buechel Rotary Club and the Middletown Woman's Club.

Henry Asman, M.D., J. P. Sanford and I attended the dedication of the new home of the Indiana Medical Society in Indianapolis.

Due to the business and scientific programs of any medical organization occurring more or less simultaneously, I have a suggestion that I believe would greatly improve our Annual Meeting. We could have the first meeting of the House of Delegates on Sunday evening, the Reference Committees on Monday and the second meeting of the House of Delegates Tuesday night; then the scientific meetings Tuesday, Wednesday and Thursday. That way, the Delegates and Officers would not have to miss the scientific meetings.

David M. Cox, M.D., Louisville
President-elect

Recommendations, Reference Committee No. 1

Reference Committee No. 1 recommends acceptance of this report and wholeheartedly concurs with the suggestion of the changes in the meetings of the House of Delegates which will be more fully covered in the recommendation of the Board of Trustees.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Speaker

This meeting marks the second full year of operation of the Association under new committee and council structure voted by the 1960 meeting of the House.

It would appear that the advantages of transacting the Association's business under the revised system are obvious to everyone familiar with the two systems. Reaching the goal of maximum efficiency of our operation with a minimum of wasted effort and time, however, requires continued planning.

For instance, this year another refinement has been initiated. All of you received your envelopes containing the full reports of the councils and standing committees. The council chairmen will present a concise summary of these reports, rather than read through the entire report, thus saving your time. We will welcome any suggestions looking toward the improvements of our procedure.

We have done our best to organize the meeting so that the Association may realize the maximum accomplishments from your deliberations, without undue stress or burden to any of you.

Your speaker, vice speaker, KSMA officers and members of the headquarters staff are at your service. Please feel free to call on us.

Sam A. Overstreet, M.D., Speaker
KSMA House of Delegates

Recommendations, Reference Committee No. 1

Reference Committee No. 1 recommends approval of the report of the Speaker and wishes to thank him for a very difficult job handled in a most diplomatic and efficient way.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Chairman of the Board of Trustees

The Board of Trustees had the busiest year it has had in the memory of many veteran observers. Not counting the meeting this afternoon, it has had seven meetings and the Executive Committee of the Board has convened five times.

The following summary of figures will reveal to you the extent of the time expended, dedication and sacrifice members of the Board of Trustees have made as a service to you, the remaining members of the profession and to the public.

Members attending meetings of the Board of Trustees and Executive Committee totaled 238, spent a total of 1,087 hours and traveled 41,536 miles in doing so.

Obviously it is not feasible to report here on all that took place in a total of 53 hours of meetings requiring 174 pages of minutes. Any member of the Association is privileged to come to the KSMA headquarters and review the minute books whenever he desires. We will undertake to summarize the more important actions of the past year.

The Board has held two day-long meetings and the Executive Committee two day-long meetings in the new KSMA headquarters office building. Immediately the Board recognized the many advantages of the Board Room the new building offered. The members enjoy it and work better in the comfort and adequacy of the Board Room. The immediate availability of Association records is a decided help—a situation we have not enjoyed before. And finally, the convenience and ease of assembling, especially for members from out in the state, and the generous parking space are just a few most appreciated advantages.

First Meeting—The reorganizational meeting of the Board of Trustees was held September 21 with Delmas M. Clardy, M.D., serving as temporary chairman. Nominations for the office of chairman of the Board for the associational year were called for and Wyatt Norvell, M.D., New Castle, was nominated and elected by acclamation.

The new members of the Board of Trustees were then recognized. They were: David M. Cox, M.D., Louisville, president-elect; Henry B. Asman, M.D., Louisville; Robert E. Pennington, M.D., London, and Walter R. Johnson, M.D., Paducah, vice presidents; George P. Archer, M.D., Prestonsburg, and J. Vernon Pace, M.D., Paducah, new AMA delegates. Newly elected trustees were Howell J. Davis, M.D., Owensboro, second district; Mitchel B. Denham, M.D., Maysville, ninth district; Clyde C. Sparks, M.D., Ashland, 13th.

William C. Hambley, M.D., Pikeville, trustee from the 14th District, was elected vice chairman. The two members from the Board who were elected to serve on the Executive Committee were Ralph D. Lynn, M.D., Elkton, trustee from the third district, and Keith P.

Smith, M.D., Corbin, trustee from the 15th district. (Composition of the Executive Committee is as follows: president, president-elect, chairman of Board, vice chairman of Board, secretary and two members of the Board.)

The Board accepted the date of May 20 as the tentative date for the dedication of the new building, and it was explained that plans had been approved for a dedication issue of The Journal of KSMA. The Board approved a recommendation of the Building Committee that not more than $15,000 be spent in furnishing the new headquarters office, including equipment, drapes, etc.

The Board agreed to meet at an early date to form the committees and councils for the new year.

Second Meeting—On October 19 the second meeting of the Board was held at the Brown Hotel. The president reported that plans were well along the way for the 1962 Interim Meeting to be held on Washington's Birthday in Owensboro. He said the program committee had an excellent meeting.

There was a discussion of the visit of Edward R. Annis, M.D., to Louisville during the annual session and all felt that his stay was highly profitable to medicine.

Plans for the Kentucky Rural Health Conference at Kentucky Dam Village were discussed and the members of the Board were urged to help promote attendance at this meeting.

A recommendation from the AMA relating to the importance of each county medical society's studying the provisions of the Joint Commission on Accreditation of Hospitals was reviewed and approved.

At this point John D. Gordinier, M.D., KSMA's medicolegal administrator, appeared before the Board and suggested that a Louisville firm of attorneys that has been retained for years for professional liability matters be released, due to the lack of utilization of their services. The recommendation was referred to the Executive Committee for further study.

The report of the Building Committee was next discussed. It was decided by the Board that the committee should proceed with the construction of the fallout shelter capable of taking care of 25 people.

It was pointed out that the debt on the new building would be $100,000 and that this could be funded at 5¼% interest by paying $15,000 per year for five years with a $25,000 "balloon" at the end of that period which would be refinanced at that time. It was understood that these payments would start April 15, 1963. This recommendation, following considerable discussion, was accepted.

The Board voted to approve the recommendation that the representative of the Kentucky State Nursing Home Association be invited to attend the Council on Allied Medical Services.

There was considerable discussion relative to the operation of the district grievance committees, after which it was decided to refer the matter to the Bylaws Committee.

The Board then heard a representative of the Christian Science Committee on Publications for Kentucky discuss the proposed compulsory immunization bill planned to be introduced at the 1962 General Assembly. The Board received the comments for information.

The Board next heard recommendations from a public relations firm relative to the possible conduction of an educational campaign on cults. The material was referred to the Council on Legislative Activities for further consideration.

The Board then heard and approved nominations for membership on the State Board of Health. Following this, the report of the Executive Committee on nominations for personnel for all councils, committees of the councils and standing committees was heard. These recommendations had been formed by the Executive Committee at a meeting the evening before and the morning of this meeting. The recommendations of the Executive Committee for personnel of all councils and committees were approved.

The Board next considered recommendations of the Executive Committee for the eight congressional district key men. These were also approved.

Appreciation was expressed to Edmund D. Pellegrino, M.D., Lexington, for serving as editor of the special symposium issue of The Journal.

The Pike County resolution presented by William C. Hambley, M.D., was referred to the KSMA Advisory Committee on Indigent Care.

Third Meeting—The Board of Trustees held its third regular meeting, a day-long session, Thursday, December 14, at the Brown Hotel in Louisville.

Replacements were made of absentees on councils and committees who had been named earlier and who could not serve.

The chairman of the Building Committee, George F. Brockman, M.D., Greenville, reported that the new Headquarters Office Building would be ready for occupancy prior to February 1. The Board authorized the purchase of a new typewriter and approved new stationery which included a miniature picture of the new building.

The Board of Trustees then voted an expression of appreciation to the Building Committee for the excellent work it had done.

On recommendations of the Council on Communications and Public Services, the Board voted to ask each county medical society to cooperate fully in the Medical Self-Help Program of Civil Defense.

Recommendations of the Council on Legislative Activities were heard. The Board authorized a bill on immunization to be introduced and gave consideration to other matters.

The Legislative Council's recommendations for the organization of the Kentucky Educational Medical Political Action Committee to be known as KEMPAC, were read and approved without dissents. The Board then proceeded to consider and elect a Board of Directors for KEMPAC. It was noted that while the directors on the Board of KEMPAC are selected by KSMA, the operation of KEMPAC is separate and apart from KSMA.

The Steering Committee report on the campaign to hold meetings in each one of the trustee districts during January and the early part of February was made by its chairman, G. L. Simpson, M.D., president. Plans for these meetings were thoroughly explained.

The Board voted to hold the 1966 Annual Meeting September 20, 21 and 22.

In other actions, the Board voted not to change its policy relative to the refunding of dues; passed a resolution commending W. Vinson Pierce, M.D., to be read at the time he was honored by the Campbell-Kenton County Medical Society, at a special dinner on December 16; voted to express appreciation to I. Alden Bishop, M.D., of Jeffersontown, for the splendid contribution he is making through the radio program *Fun Fair P.M.* on WHAS and finally the Board voted to extend invitations to the Deans of both Medical Schools to attend its meetings as guests of the Board whenever possible.

Fourth Meeting—The fourth meeting of the Board of Trustees was held Wednesday, February 21 at Owensboro. The president reported that there had been meetings in all 15 of the trustee districts within a five-week period, attended by 1,099 people. He said a total of 56 speakers had taken part in the campaign to acquaint the profession in Kentucky with the weaknesses of King-Anderson legislation.

It was announced that the headquarters staff had moved into the new KSMA headquarters office building on January 26. The chairman of the Building Committee said that the first committee meeting to be held in the new structure was the Advisory Committee to the Editor on February 15. He said the Building Com-

mittee had already heard many compliments on both the exterior and interior. He discussed briefly plans for the dedication on May 20.

Following the replacement of vacancies in the committee structure, the Board voted to hold a special meeting within the next 30-45 days to consider recommendations of the Advisory Commission to Blue Shield relative to a program of medical care for senior citizens in Kentucky.

The importance of expediting the appointments of the councils, their committees and the standing committees of the Association at earlier dates than is currently practiced was discussed at length. The question was referred to the Bylaws Committee for study.

The Board accepted a recommendation of the KSMA Council on Medical Education and Hospitals that the KSMA recognize superior work done by members of the faculty of each of the two medical schools in Kentucky each year. It was decided that the deans of the two schools, together with the chairman of the Council on Medical Education and Hospitals, would serve as a committee to select the award winners.

The Council on Legislative Activities reported on the status of legislation in Frankfort that KSMA was resisting and legislation that KSMA was supporting. Mitchel B. Denham, M.D., trustee from the ninth district and representative from the 65th district, Maysville, explained the bills. John C. Quertermous, M.D., chairman of the Council on Legislative Activities for National Affairs, reported on the National Legislative Conference sponsored by the AMA. He discussed with members of the Board strengthening of the campaign against the King-Anderson Bill which was pending in Congress.

Austin Smith, M.D., Washington, D. C., former editor of The Journal of the AMA and now president of the Pharmaceutical Manufacturers Association, who was in Owensboro for the Interim Meeting the next day, spoke briefly to the Board about the problems common to both the pharmaceutical industry and the medical profession.

The Board accepted a recommendation of the School Health Committee that it sponsor a series of at least five athletic injury regional conferences throughout the state during the coming year.

The chairman of the KSMA Technical Advisory Committee on Indigent Medical Care, Clyde C. Sparks, M.D., Ashland, was then heard. Doctor Sparks said the Technical Advisory Committee had studied the Pike County resolution at considerable length. He felt that the members of the Committee agreed in principle with the points set forth in the resolution but felt it could not be implemented under the Kerr-Mills program without a loss. Moreover, he explained that the law specifies that payments be made to the vendor. He said it was the committee's conclusion that it would not be practical to implement the resolution at this time. The matter of giving out-patient care under the indigent care program was given lengthy consideration. It was agreed that the matter should be given further study and be considered at a later date.

The Board expressed appreciation to the American College of Obstetricians and Gynecologists and to the Southern Surgical Association for generous contributions made to the McDowell House. It voted to give a contribution of $150 to the University of Louisville and and to the University of Kentucky chapters of the Student AMA, in order that each chapter might send delegates to their national meetings.

Fifth Meeting—The fifth meeting of the Board of Trustees was held Thursday, March 29 in the Board Room at the headquarters office building.

Following the call to order and announcements, along with the approval of the minutes of the last meeting, the Board heard the President's report and the report of the Headquarters Office.

As a special item of business, the Board expressed its appreciation to the Medical Research Foundation, George F. Brockman, M.D., Greenville, president, for a substantial gift that was made to the Association to assist in providing quarters for the Rural Kentucky Medical Scholarship Fund in the new Headquarters building.

The Board then accepted a recommendation of the KSMA Committee on Public Health that "every physician who sees a child under 12 months of age, or at any age for that matter, shall see that the child has been immunized against diphtheria, pertussis, tetanus, polio and smallpox and that all local health departments encourage persons who are able to obtain such immunization from their private physicians."

The Board then heard reports from representatives who attended the meeting on health care benefits and Social Security in Chicago and the mental health conference in Chicago earlier this year. It was recommended that digests of these reports be carried in The Journal of KSMA.

The Board then acted unfavorably on a proposal of a pharmaceutical company to contribute $250 to the expense of a guest speaker at the Annual Meeting in lieu of exhibiting in the technical exhibit hall at the annual session.

The Board next heard Clyde C. Sparks, M.D., chairman of the KSMA Technical Advisory Committee on Indigent Care, discuss certain problems faced by the committee. It then clarified the Association's policy with respect to its views on matters relating to out-patient care in hospitals.

Members of the Board were acquainted with the conference to be held in St. Louis April 14-15, sponsored by the AMA Council on Medical Service and the National Association of Blue Shield Plans.

The Board was then brought up to date on the status of the King-Anderson Bill and other matters before Congress with special interest to medicine. A summary of bills with medical and health implications introduced into the 1962 Kentucky Legislature and what happened to them was given to the Board.

The Board acted favorably on a recommendation from the Council on Legislative Activities that it recommend one of its members active in legislative matters to the Awards Committee for consideration as a nominee for the Distinguished Service Medal.

A recommendation that the Governor be thanked by the Board for his support of health objectives of the Association was unanimously passed.

The Chairman of the KSMA Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., was introduced and asked to present the recommendation of the Commission—the primary reason for the calling of this meeting. The recommendation was that the KSMA Board of Trustees accept and support the proposed joint program for medical care for the aged as announced earlier in the year by the AMA and the National Association of Blue Shield Plans.

Following approximately two hours of discussion, the Board passed a motion without dissenting vote that it approve the recommendation of the Advisory Commission and present it to a full meeting of the KSMA House of Delegates.

In another action, the Board recommended that the delegates, county society secretaries and legislative key men receive full information and that all county societies be urged to consider this matter carefully before sending their delegates to the special meeting of the House which was set for Thursday, April 12.

A recommendation that the U. S. Public Health Service proposal to conduct a highway safety survey in Kentucky be approved was adopted.

It was decided that the next meeting of the Board would be held at 10 a.m. Sunday, May 20, in the Board Room of the Blue Cross-Blue Shield Building, just prior to the dedication ceremonies of the new KSMA Headquarters Building at 2 p.m. that afternoon.

Sixth Meeting—The sixth meeting of the Board was held on Sunday, May 20, at 10 a.m. Following the reports of the president and the headquarters office,

the chairman explained the activities that would follow the meeting in connection with the dedication of the new headquarters office building that afternoon.

Keith P. Smith, M.D., Corbin, chairman of the Budget Committee, before presenting the proposed budget for the 1962-63 fiscal year, said that his committee had spent a full day working on the proposal and that it had been given lengthy consideration by the Executive Committee of the Board of Trustees which had recommended the proposed budget to the Board.

He explained that there were no large changes in the budget that was proposed for the 1962-63 year as compared to the one now in operation.

The budget, as approved by the Budget Committee and the Executive Committee, was approved by the Board with the exception of the postgraduate medical education program appropriation. The Board wanted more information before acting on this segment of the KSMA's activity and delayed acting on this until its July 26 meeting.

Doctor Smith then presented the recommendation of the Budget Committee with respect to the Association's overall financial position. He said the Budget Committee had considered the advantages of retiring the $100,000 debt on the new building during the year of 1963. He said if this could be done it would save the Association over $21,000 in interest over the next six years. He pointed out that the Budget Committee had found the total cost of the building greatly exceeded the original recommendations of the Building Committee due to the following facts:

(1) The architects substantially underestimated construction costs.

(2) Two more lots had been purchased and

(3) Certain additions to the building were voted by the Board of Trustees after the original estimate was made. It was also noted that the Building Committee had recommended a 20-year amortization of the debt, whereas the trustees had elected to pay it off in six years.

Following considerable discussion, it was decided to recommend to the House of Delegates that an assessment of $50 per member be voted for the year 1963 and that the proceeds from this would be used to pay off the debt on the building.

Other actions included accepting a recommendation of the Council on Medical Education and Hospitals to establish a committee on mental health. Where to hold the 1963 Interim Meeting (formerly County Society Officers Conference) was deferred until the July 26 meeting of the Board. A committee was appointed to purchase a lawnmower and the chairman of the Board of Trustees was authorized to nominate three members for consideration by the Governor to fill a vacancy that will develop on the Hospital Licensure Council July 1.

It was pointed out that the business community was protesting the fact that some physicians were supporting government ownership of industry as opposed to private ownership of industry. The Board, following discussion, voted to urge the KSMA membership to use its influence to forestall the socialization of private industry in Kentucky.

Leonard W. Larson, M.D., Bismarck, N. D., AMA President who attended the Board meeting and had been recognized earlier, briefly addressed the Board.

Seventh Meeting—The seventh meeting of the Board of Trustees was held July 26 in the Board Room at the headquarters office. The president indicated in his report that he had addressed the annual meeting of the Kentucky Pharmaceutical Association.

Robert C. Long, M.D., senior delegate to the AMA, reported on the annual meeting of that House of Delegates in June.

In the report of the headquarters office, it was explained that about a year ago William E. Rudd had left the employment of the Association for a job in a business he was formerly with at a substantial increase in salary. Following this, Robert G. Cox, who was experienced in association work, was employed. Before the members of the Board could meet Mr. Cox, he was called into service of the 100th Division late in the month of August. Tevis Bennett was then employed with the full knowledge of the situation. It was not known how long the 100th Division would be in service, neither was there any information on whether Mr. Cox would want to come back to the Association following his separation, whenever this might be.

When it was known that the 100th Division would be coming back in August, Mr. Cox indicated that he was looking forward to returning with great enthusiasm and working for KSMA. Contacts were made in behalf of Mr. Bennett and two offers in medical organization work were made to him. However, the headquarters office of the Kentucky Farm Bureau Federation made Mr. Bennett such an attractive offer that he decided to accept. This Association is very grateful for Mr. Bennett's services and feels that he has a bright future. We wish him well. At the same time, we welcome Mr. Cox's return and are looking forward to working with him.

The Board then passed separate motions, one thanking Mr. Bennett for his services and another thanking Mrs. Margaret Wallace who had served as reporter for the past three years and who is retiring to start her family. Letters of appreciation were voted for each of the two employees.

It was also indicated that the KSMA Highway Safety Committee had been able to induce Cornell University to conduct a crash injury research program in Kentucky. Approval was given to the Hometown Medical Care contract on the recommendation of the KSMA Committee on Federal Medical Services.

Sam A. Overstreet, M.D., was reelected to serve a third two-year term as editor of The Journal of KSMA. It was reported that George W. Pedigo, Jr., M.D., had resigned as associate editor. Walter S. Coe, M.D., Louisville, was elected for a two-year term to succeed Doctor Pedigo.

On the invitation of Dexter Meyer, M.D., Covington, trustee for the eighth district, the Board voted to hold the 1963 Interim Meeting in Covington. The date for this session had previously been selected as March 7.

At this time the Board considered the action it had taken at the May 20 meeting relative to recommending the $50-per-month assessment during 1963 for the purpose of paying off the indebtedness on the new building. Following full consideration: "While the Board of Trustees feels that there is substantial merit in retiring the entire indebtedness on our building with a one-time assessment of $50, thus saving the Association more than $21,000 in interest, the Board upon more mature consideration does hereby rescind its recommendation made at the May 20 meeting that there be an assessment next year."

The Board then considered the status of the King-Anderson Bill and the defeat of the Anderson Javits amendment to S. 10606 which was essentially the same as the King-Anderson Bill. The Board voted to express appreciation to those individuals and groups who offered resistance to the passage of compulsory coverage under Social Security for the aged. The Board also expressed appreciation to the AMA for the vigorous campaign it had waged against this undesirable legislation.

No action was taken by the Board on a request that KSMA declare as ethical the operation of a corporation of professional associations as provided for under H. B. 97 passed during the 1962 Legislature. It was indicated that the AMA in 1958 had stated that the general idea was ethical; however, it was decided that pending final rulings of the Department of Revenue of this state on certain matters in this field KSMA would not take action at this time.

The president-elect was recognized and discussed some of the matters he proposes for his administration

during the coming year. This included more vigorous resistance to King-Anderson type legislation, ways and means of improving present programs for care of the indigent and aged and plans for the Interim Meeting to be held March 7 in Covington.

Following presentation by representatives of the Kentucky Chamber of Commerce, the Board voted unanimously to support the request that members of KSMA join the Kentucky Chamber.

The Board then considered the matter of who should pay for the services of the KSMA attorney when an individual physician or a county medical society requests his services. Following consideration of a previous ruling on this and other thoughts, the Board voted to pass the following motion: ". . . that the manner of handling such requests remain as is and if the Executive Committee, which makes the decision on the individual cases, feels that a question is of importance to the general membership that this information be disseminated to the general membership. If the member is to be charged for legal advice on a particular matter he shall be told in advance that he will be charged on an individual basis. If an individual doctor has a question that is urgent, that doctor shall be advised that an opinion will be obtained for him and at the next meeting of the Executive Committee it will conisder whether or not the Association or the individual should pay for the legal advice."

The Board then heard, as required by the Bylaws, the reports of the councils and standing committees to the House of Delegates—six councils and eight committees—and acted on each. When the Board considered the budget for the 1962-63 associational year on May 20, it acted on all recommendations except that of the appropriation for $10,000 for the Committee on Postgradaute Medical Education. It was agreed at that time that this matter would be reconsidered following the report of the Postgraduate Medical Education Committee which the Board had heard just shortly before. It was voted to appropriate money on a pro rata basis for the committee to operate until October 1 and that the Board reconsider the matter at its September 17 meeting. It was agreed that Walter S. Coe, M.D., chairman of the Committee on Postgradaute Medical Education, be invited to comment. It was further agreed that the Board would make the recommendation at that time to the House of Delegates for the final disposition of the matter.

The Pike County resolution was again considered at the request of Doctor Hambley. It was agreed that the resolution would receive further consideration at the September 17 meeting of the Board.

At the conclusion of the meeting the chairman, Doctor Norvell, presented to the Association's museum two volumes of Brathwaite's Retrospect of Medicine and Surgery, the oldest being published in 1842.

Wyatt Norvell, M.D., Chairman
KSMA Board of Trustees

Recommendations, Reference Committee No. 1

Reference Committee No. 1 recommends acceptance of the report of the Chairman of the Board of Trustees with the exception of those portions of report number four which have been delegated to committees two and seven.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Secretary

The 1961-62 Associational year has been one of the most eventful in the life of our organization. It would appear that one of the most significant developments has been the greater recognition and acceptance of responsibility by our membership with more work done and more solid accomplishments realized than in any other year during our observation.

The members of our profession are becoming more and more aware that the exponents of socialism, some misguided supporters, and political opportunists have been trying to foist upon the American public piecemeal legislation which would centralize the control not only of the health professions in Washington, but also education, agriculture, utilities, etc. In this battle of resistance each group is called upon to do its part as well as support other groups in their fight. We are glad to say that men in medicine have accepted this responsibility in increasing numbers.

Under the aggressive and effective leadership of our president, G. L. Simpson, M.D., and with the full and active cooperation of the Board of Trustees, each one of the 15 KSMA trustee districts held meetings to consider national legislative problems within a five-week period ending early in February. More than 1000 people attended these 15 meetings, which featured four carefully prepared talks. This was the beginning of a campaign in which Kentucky did its part to bring about the ultimate defeat of the King-Anderson type legislation in this second session of the 87th Congress.

At the 1962 General Assembly in Frankfort, the KSMA was recognized as a potent influence in supporting legislation in the public interest. Chief among these matters was the immunization law, which was passed over the determined resistance of some of the cultist groups.

The KSMA Council on Legislative Activities and the efforts of our maturing and increasingly effective statewide system of KSMA legislative key men deserves the Association's highest praise for their collective good work. At the time this report was written, the Council on Legislative Activities was in the midst of conducting a survey which was very revealing from two points of view: One, the number of counties who participated wholeheartedly in the resistance of King-Anderson legislation; and two, in some situations there was a discouraging lack of organization and expended effort.

During the past year there has been created by the medical profession in Kentucky an organization known as the Kentucky Educational Medical Political Action Committee. This organization functions at the state level in very much the same way as the American Medical Political Action Committee functions at the national level. The organization performs for medicine in the field of political action those duties which KSMA cannot legally undertake. The new organization has already demonstrated its great importance to the profession and to the people of Kentucky and certainly we feel that every physician in Kentucky interested in maintaining the American way of life should and will want to support KEMPAC.

Our socialist friends can lose and lose and lose again, but if medicine loses once, it is lost for good. In defeating King-Anderson type legislation this year, we have won only a battle—not the war. They will be back fighting harder than ever, which means we will have want of a more effective attack next year if we are to win.

Another significant event in the life of our 111-year-old organization was the dedication of the headquarters office building here in Louisville on May 20. While the many benefits to the Association of having a new headquarters office building are too numerous to enumerate here, you will be interested in the fact that because of the new building people from all over the state are more aware of our Association's presence as a service organization than ever before. You will also be glad to know that already 27 KSMA groups and nine related organizations have met in our building in the first six months of its occupancy.

During the past three years KSMA has received national recognition for three publications it has developed. Copies of these publications were requested by the AMA and sent to all component state medical associations. These publications were the brochure which served as a program memento of the dedication of the headquarters office, the KSMA legislative key man booklet and the leaflet designed to promote at-

tendance at the technical exhibit hall during the Annual Meeting.

The Highway Safety Committee was able to bring the Cornell University Automobile Accident Injury Survey Program to Kentucky. This survey will require approximately three years to accomplish and Kentucky is the 23rd state which is fortunate enough to have this program. The format for the study calls for surveying approximately 10 counties divided into two groups, usually in different sections of the state, at a time.

The Committee on Emergency Medical Services has been working very closely with the State Civil Defense Program and the State Department of Health. It has taken the leadership in promoting the self-help program in Kentucky that the National Civil Defense Administration is advocating.

In addition to promoting the statewide conference on athletic injury prevention at the University of Kentucky in Lexington in August, the KSMA School Health Committee has lined up a program of six regional athletic injury prevention conferences in cooperation with the Kentucky High School Athletic Association and local colleges. When it is realized that these six regional conferences will be held on successive Saturdays, the amount of work involved can be appreciated.

As concrete evidence of the depth of KSMA activity during the past year, we would like to report that the six councils of the Association held a total of 16 meetings. A total of 89 members attended these council meetings. They spent 312 man hours in session and traveled a total of 13,952 miles. In addition, there were 45 KSMA committee meetings attended by 210 members who spent 610 man hours and traveled 29,012 miles as these council and committee appointees undertook to carry on KSMA activity.

The work of the KSMA councils and committees has moved forward on all fronts. We have only attempted to list some of the more spectacular increases in activity. You have only to review the contents of your House of Delegates envelope to realize how much work is taking place and the many valuable contributions your Association is making both to the profession and to the public. We believe as you undertake this review, you cannot help but feel a glow of pride in the many accomplishments of your organization.

We would like to report that the KSMA executive secretary has been made a member of the Board of Directors of the Medical Society Executives' Association, a nationwide organization composed of some 350 physicians and lay people engaged in medical organization work. The primary purpose of this organization is to carry on continuing programs of education for the active members and special training programs for new members.

We want to express our appreciation to the officers and members of the Board of Trustees, committees and councils for their fine accomplishments. It has certainly been our pleasure to work with them. We want also to express our appreciation to the members of the KSMA headquarters staff for their cooperation with my office.

Woodford B. Troutman, M.D.
KSMA Secretary

Recommendations, Reference Committee No. 1

Reference Committee No. 1 wholeheartedly accepts the report of the secretary.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Editor of The Journal

We want to welcome Walter S. Coe, M.D., Louisville, to the staff of The Journal of KSMA. He was elected associate editor by the Board of Trustees at the July 26 meeting. Doctor Coe succeeds George W. Pedigo, M.D., who served as associate editor for the past four years. In accepting Doctor Pedigo's resignation, the Board expressed appreciation for his good work during his term of office and regrets his decision to resign. The members of the staff join me in expressing gratitude for Doctor Pedigo's valuable contributions.

A special feature of The Journal each year is the symposium issue which usually appears in October. We want to express appreciation to the special symposium editor, Edmund D. Pellegrino, M.D., Professor and Chairman of the Department of Medicine at the University of Kentucky, for his excellent work in 1961. We would also like to call attention to the 1962 issue on which Beverly T. Towery, M.D., Professor and Chairman of the Department of Medicine, University of Louisville, will serve as editor.

The April 1962 number of The Journal was designated as the dedication issue for the new KSMA Headquarters Office Building. All of us were gratified that this issue received national recognition.

One of the recommendations that came out of an excellent meeting of our Advisory Committee to the Editor (which was the first committee meeting held in the new KSMA Headquarters Office Building) was the development of a new cover for The Journal. The art work for this new cover is now being prepared. We would like to express appreciation to the Advisory Committee and its chairman, George F. Brockman, M.D., for its interest and effective support in the continuing program to improve The Journal.

And now, gentlemen, your Editor appeals to you and your colleagues to support our advertisers in every ethical way possible. The threat of government regulation, the activities of a Senator from Tennessee, and competition from other media, have resulted in a substantial reduction in our revenue. While our loss of revenue has been about 4 5/10% less than the average, it is, we repeat, substantial. Our advertisers, through revenue we derive from their insertions in our Journal, make it possible for us to print the type of publication we have. They deserve our patronage.

Sam A. Overstreet, M.D., Editor

Recommendations, Reference Committee No. 1

Reference Committee Number 1 accepts the report of the editor and wishes to state its gratitude to Doctor Pedigo for his excellent work in the past year. The Committee wishes to extend a greeting to Walter S. Coe, M.D., and welcome him to the staff.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Treasurer

Reference Committee No. 1 recommends acceptance of this report and wishes to commend Delmas M. Clardy, M.D., and other members of his committee for a difficult job well done. Full report of the Treasurer is available to members in the headquarters office.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Delegates to the American Medical Association

A very complete report of the proceedings of the House of Delegates of the American Medical Association at the Interim Session held in Denver, Colo., November 26-30, 1961, and the Annual Session held in Chicago, Ill., June 24-28, 1962, have previously been reported in the February and August Journals of the Kentucky State Medical Association, respectively. Therefore, it seems appropriate that this report should highlight the important actions of the House.

The Interim Session of the American Medical Association, held at Denver, was highlighted by the approval of the House of Delegates of the American Medical Political Action Committee. This far over-

shadowed any other piece of business that came before the House of Delegates. There was great enthusiasm throughout the House concerning the formation of this political arm of Organized Medicine. Indeed it is a privilege to report that voluntary contributions of the members of the House of Delegates of the American Medical Association to AMPAC at that meeting was approximately $10,000. As many of you know, great strides have been taken by AMPAC since its formation. At this writing almost every one of the 50 States has a State Chapter. We in Kentucky have KEMPAC —Kentucky Educational Medical Political Action Committee. This organization has been active now for several months, and daily is increasing its membership of doctors and their wives. Your delegates and alternate delegates to the American Medical Association strongly urge that every physician and his wife in the State of Kentucky become members of KEMPAC. In this way, all of us can participate in an organized effort to fight for the survival of the private practice of medicine under the free enterprise system.

The second most important piece of business that came before the House of Delegates in Denver was a proposed amendment received from the Council on Constitution and By-Laws which would have made it possible to implement a recommendation by the Medical Disciplinary Committee that was approved by the House at the June 1961 meeting. This recommendation was to change the By-Laws so as to confer original jurisdiction on the American Medical Association to suspend and/or revoke the AMA membership of a physician found guilty of violating the principles of medical ethics, or the ethical policies of the Association, regardless of whether or not action had been taken against him at the local level. However, after considerable discussion on the floor of the House, the proposed Amendment was referred back to the Council on Constitution and By-Laws.

At the annual meeting of the House of Delegates in Chicago in June 1962, the most important items that came before the House were again in the field of legislation, political action committees, medical discipline, and the enlargement of the Board of Trustees of the AMA.

The House received 17 resolutions expecting full support of the Kerr-Mills program and firm opposition to the King-Anderson type of legislation. The House declared that "the Kerr-Mills method should be given a fair and reasonable chance to meet the need and thus remove the demand for further Federal legislation."

In regard to the subject of medical discipline referred to earlier in this report, the House approved a change in the By-Laws under which a proposed section 1 (B) of chapter 4 will now read,

> "In addition to such disciplinary action as may be taken under the Constitution and By-Laws of a component society and constituent association to which the member belongs, or when a state medical association to which a member belongs requests the American Medical Association to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by the American Medical Association, the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the American Medical Association from AMA membership only for an infraction of the Constitution or these by-laws or for a violation of the principle of medical ethics."

The House approved a report of the ad hoc committee on the Board of Trustees which recommended the size of the Board be increased from 11 to 15 members. This will be accomplished by adding three elected members and by including the immediate past president of the Association for a one year term. The House also accepted a Committee recommendation that set the term of office for elected Board members at three years and limited the number of terms to three for a maximum total of nine years' service. To implement the House action the Council on Constitution and By-Laws submitted changes in the Constitution and By-Laws for consideration at the 1962 Clinical Meeting.

In conclusion, I would like to express my deep appreciation to my fellow delegates, George Archer, M.D., of Prestonsburg, and Vernon Pace, M.D., of Paducah, and to our alternate delegates, Carl Cooper, M.D., of Bedford, Thomas Giannini, M.D., of Louisville, and John Quertermous, M.D., of Murray, for their invaluable assistance at these meetings. In addition, we, your delegates and alternate delegates, would like to express our profound thanks and appreciation for the help of so many doctors, both in and out of the official family of the Kentucky State Medical Association, who voluntarily assist us in the work of the delegation. I also wish to recognize the fine work of Joseph P. Sanford, Bobbie Grogan, and others without whose efficient help and guidance your delegation could not perform its duties efficiently.

Robert C. Long, M.D.
Senior Delegate
AMA

Recommendations, Reference Committee No. 1

Reference Committee No. 1 recommends acceptance of this report and wishes to compliment Doctor Long for his diligence in serving so successfully as the delegate to AMA from Kentucky.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Executive Secretary

With more and more members of the Kentucky State Medical Association becoming interested in and accepting responsibilities for carrying out programs for service sponsored by the Association, there is a corresponding increase in the KSMA headquarters office activity. The reports in your envelope will show a decided increase in the work undertaken by the various committees, councils and the Board of Trustees during the 1961-62 associational year.

Activities of the members of your KSMA headquarters staff fall into three broad categories:

First: Implementing policies and directives of the House of Delegates, Board of Trustees, officers, councils and committees.
Second: Administrative and housekeeping.
Third: Publications and exhibits.

An impressive total of 72 meetings was held by the Board of Trustees, councils and committees during the 1961-62 associational year. To attend these meetings, 537 members traveled 84,480 miles and spent 2,018 hours in these activities. Members of the headquarters staff under appropriate supervision promoted these meetings, set up the agendas, prepared the minutes and implemented the policies and programs that were developed. In another way of saying it, members of the staff spent a total of more than seven 40-hour weeks just attending these meetings.

The above figures, as significant as they are, do not include activities by members of the staff in connection with the regular and special meetings of the House of Delegates, the Interim Meeting, Senior Day, Rural Health Conference, state and regional athletic injury prevention conferences, the regular 7:30 Monday morning meeting of the editors in the headquarters office or the numerous consultations that members of the staff have with officers and committee chairmen.

Not included in the above is the fact that the director of field services spent the entire period in which the 1962 General Assembly met in Frankfort or the

fact that members of the staff, under the supervision of the chairman of the Board and the president, set up 15 trustee district meetings, carried on the promotional activities and committed more than 60 speakers for these 15 meetings within a five-week period ending early in February.

The staff was privileged to participate in the preparations of the dedication of the new headquarters office building on May 20.

Under the second category, administration and housekeeping, many of the less dramatic and very important staff activities are carried on. These include maintaining the financial records, membershp records, purchasing, correspondence, filing, care of the building and grounds, etc.

Careful plans were made to move the headquarters office operation during the fall and early winter into the new headquarters office building. We would like to compliment the members of the staff on carrying out this operation with the very minimum of inconvenience to the Association's leadership.

The third category of activity includes publications and presentation of exhibits. The most important of all these, of course, is the gathering, coordinating and meeting the deadline for The Journal of KSMA each month. All material for The Journal is collected by the headquarters staff and with the exception of the scientific articles, editorials and certain departments, writing that appears in The Journal is carried on by the staff.

Under appropriate supervision, material for the two monthly newsletters is gathered, written and processed. Other publications include news releases and special leaflets or pamphlets designed for certain usage. Three of these publications which received national acclaim were referred to in Doctor Troutman's report.

Considerable time is employed by the staff in presenting health education exhibits at the Kentucky State Fair, the Kentucky Education Association annual meeting and other groups that officers and committees of the Association direct. Numerous news releases are prepared and distributed for both statewide and regional use—depending on the activity.

As the Association maintains its interest in related activities and groups, members of the staff have represented the Association during the past year at 91 such meetings. These include rural health, highway safety, civil defense and civic group health activities. Here the staff has an opportunity to obtain information of interest to medicine and to present medicine's point of view.

Members of the staff attended 17 out of state meetings—many sponsored by the AMA—that dealt with legislation, medical journalism, voluntary health coverage and public service activities.

We are grateful to the officers, members of the House of Delegates, Board of Trustees, councils and committees for the opportunity of working with you; and we want to express our deep appreciation for your consideration, cooperation and tolerance of our shortcomings as we work together to serve the profession and the people.

Our deep appreciation to the Building Committee for its consideration and dedicated labors in giving us a "shop" which makes possible the maximum efficiency of our efforts. Also, we express our gratitude to our secretary, Woodford B. Troutman, M.D., and to our editor, Sam A. Overstreet, M.D., for their time and consideration as they direct our efforts.

We welcome back to our staff Robert G. Cox as executive assistant. Three days after his employment last year to succeed William E. Rudd, he was called into military service with the 100th Division at Fort Chaffee. We thank Tevis L. Bennett who served as the interim executive assistant during Mr. Cox's absence and extend our best wishes to him in his new position with the Kentucky Farm Bureau.

And finally, my unbounded appreciation and gratefulness to the other members of our headquarters staff for their solid record of performance, their dedication and cooperation as they served so faithfully this past year.

J. P. Sanford, Executive Secretary

Recommendations, Reference Committee No. 1

Reference Committee No. 1 recommends acceptance of the splendid report of the Executive Secretary, Joseph P. Sanford.

Mr. Speaker, I move acceptance of this section of the report. (The motion was seconded and carried.)

Resolution I
Campbell-Kenton County Medical Society

Be it resolved that the House of Delegates institute a study of the apportionment of Trustees to the Kentucky State Medical Association with a view toward equal representation.

Recommendations, Reference Committee No. 1

The subject of this resolution is the Apportionment of Trustees. Reference Committee No. 1 accepts this resolution and refers it to the Board of Trustees for appropriate action.

Mr. Speaker, I move acceptance of this section of the report. (The motion was seconded and carried.)

Resolution J
Fayette County Medical Society

WHEREAS, the Fayette County Medical Society desires the Kentucky State Medical Association to meet in Lexington in 1963, and

WHEREAS, the Fayette County Medical Society has voted to invite the Kentucky State Medical Association to meet in Lexington in 1963, or thereafter, depending on suitable investigation and arrangements, and

WHEREAS, the Lexington Chamber of Commerce assures us that approximately 3,000 persons can be accommodated in hotel and motel facilities,

THEREFORE be it

Resolved, that the Kentucky State Medical Association hold its 1963 meeting at the Phoenix-Lafayette Hotels, Lexington, Kentucky.

Recommendations, Reference Committee No. 1

The subject of this resolution is Invitation Kentucky State Medical Association to Lexington in 1963. This reference committee recommends the acceptance and implementation of this resolution if appropriate arrangements can be made.

Mr. Speaker, I move acceptance of this section of the report. (Following the seconding of the motion that the reference committee's recommendation be accepted, an amendment was offered to the effect that KSMA express its thanks to Fayette County for the invitation. The amendment was accepted by the committee chairman and the seconder, and upon being put to a vote, the motion as amended was adopted.)

Resolution L
Jefferson County Medical Society

WHEREAS, we note the resignation of George W. Pedigo, M.D., as Associate Editor of the KSMA Journal, and

WHEREAS, we are aware of his considerable contribution to the KSMA Journal over the past four years as it continues to improve in content and appearance, thus holding a position among the best medical journals in the country, and

WHEREAS, we realize the tremendous amount of time and effort necessary from the entire Editorial Staff to consistently publish a Journal of this size, therefore

BE IT RESOLVED, that this House of Delegates express its appreciation to George W. Pedigo, M.D., for his past service and extend commendation to Sam A. Overstreet, M.D., Editor, and all who serve with him on the staff, departments, committee, and consulting board, for their service to medicine in Kentucky.

Recommendations, Reference Committee No. 1

The subject of this resolution is Commendation and Appreciation for Editors of KSMA Journal. Reference Committee No. 1 accepts and implements the commendation and appreciation extended to George W. Pedigo, M.D., and Sam A. Overstreet, M.D.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Recommendations, Board of Trustees, Changing of the Meetings of the House

The Board of Trustees this afternoon considered a recommendation that the date of the House of Delegates first meeting be changed from Monday night to either the Sunday afternoon before or the following Monday morning and that the Reference Committees go into session that Monday afternoon.

The reasons are as follows:

1. Competition of Reference Committee meetings with Scientific Sessions Tuesday afternoon.

2. Reference Committees would have more time to review and formulate recommendations on the reports to the House of Delegates.

3. Provide more time for the accurate processing of these reports.

Following consideration the Board of Trustees voted to recommend to the House of Delegates that (1) the first meeting of the House of Delegates be held at 9 a.m. on Monday, (2) that the Reference Committees be held that Monday afternoon, (3) that the Reference Committees submit their reports for processing by noon Tuesday. It was requested that the House of Delegates' envelopes containing all reports for the year to the House be mailed two weeks in advance, thus providing adequate time for each county medical society to schedule a meeting to consider the reports officially and those who wish to also could plan to present to the reference committees their counties' views.

Recommendations, Reference Committee No. 1

Reference Committee Number 1 accepts and implements this recommendation.

Mr. Speaker, I move acceptance of this section of the report. (Motion was seconded and carried.)

Mr. Speaker, I move the acceptance of this report as a whole. (Motion was seconded and carried.)

Reference Committee No. 1

W. R. Byrne, M.D., Russellville, Chairman
Eugene L. Marion, M.D., Glasgow
T. N. Perry, M.D., Jenkins
Ballard Cassady, M.D., Pikeville
George H. Widener, M.D., Paducah

REFERENCE COMMITTEE NO. 2

Guinn S. Cost, M.D., Chairman
Reports on Scientific Assembly and Medical Education

Report of the Council on Scientific Assembly

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Scientific Assembly is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

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One meeting was held by the KSMA Council on Scientific Assembly for this associational year on December 6, 1961.* At this meeting, thorough consideration was given to the over-all policies of the 1962 annual session.

For the first time, the idea of asking each specialty group to invite a speaker who would fit into a series of symposia that was prearranged was discussed and approved.

Later the chairman of the scientific program presented this to the Program Committee and to the specialty group presidents, who accepted the suggestion and who have cooperated fully. It is felt that this new procedure, although a bit more tedious to operate, will greatly benefit the membership through the improved content of the scientific program.

The Council approved the invitation to F. J. L. Blasingame, M.D., executive vice president of the AMA, to be the speaker at the President's Luncheon. It also expressed its appreciation to the Smith, Kline & French people for being willing to present on Wednesday afternoon, September 19, another hour-long transatlantic CPC. This year the team from overseas will be composed of internationally known physicians practicing in Glasgow, Scotland, and the general subject will be renal disease.

During the meeting of the Council, broad policies for all aspects of the Annual Meeting were considered and approved.

The Council would like to express its deep appreciation to the chairmen and members of the various committees of our Council who have worked so energetically and effectively in presenting what we believe will be one of the best Annual Meetings our membership has enjoyed.

Program Committee, Edmund D. Pellegrino, M.D., Lexington, Chairman

The Scientific Program Committee met twice during the 1961-62 associational year. Attendance was good at both meetings and members of the committee participated effectively and with enthusiasm.

At the first meeting of the committee, it was decided to implement the suggestion that fewer subjects be covered and in greater depth. It was agreed that the program should be planned around certain basic subjects. In order to carry out this plan, the cooperation of the specialty groups was necessary in selecting outstanding speakers to participate in these predetermined areas.

The chairman then met with the 14 specialty group presidents at a special session in Louisville. They accepted the proposal and have cooperated well with our committee in its implementation.

Following receipt of the information provided by the specialty group presidents, the committee met again and proceeded to structure the program. This system is an innovation in our Association. We believe the

**Because of the nature of this Council's business, the House of Delegates in 1961 voted to require the Council on Scientific Assembly to meet only once during the year.*

new practice has considerable promise and provides an opportunity for somewhat greater flexibility in program planning.

The chairman also met with representatives of the Smith, Kline & French Laboratories in planning for a Transatlantic CPC which is to be held at 2 p.m. on Wednesday, September 19. An interesting presentation and discussion with our British colleagues is anticipated.

The chairman wishes to express his appreciation not only to the other members of his committee but also to the 14 specialty group presidents who cooperated so effectively in this whole matter. The committee would like to urge attendance at this program and hopes that you agree that the material and the speakers are of high quality.

Scientific Exhibits Committee, J. Alex Haller, Jr., M.D., Louisville, Chairman

The Scientific Exhibits Committee, composed of J. Alex Haller, M.D., chairman, Benjamin B. Jackson, M.D. and Richardson K. Noback, M.D., has reviewed 16 applications for scientific exhibits for the fall meeting of the Kentucky State Medical Association. After individual consideration these findings were reviewed at the committee meeting on June 19 and space allotted for 16 exhibits, the list of which is appended. The committee was generally pleased with the caliber of the application and also by the wide range of medical topics which were covered.

At Doctor Jackson's suggestion, an entirely new area for the exhibits will be utilized this year. The entire lobby area of the Columbia Auditorium will be set aside for the exhibit space. There will be two aisles of exhibits which will necessitate passage by all members and guests going to and from the main conference room. This will not only make it easier for adequate study of the exhibits but will also increase the facility with which the exhibitors will come in contact with the membership of the Kentucky State Medical Association.

It was decided that there would be an award for the best exhibit. This would be a medallion (if a proper die can be struck) with the emblem of the Kentucky State Medical Association upon it. It was felt that this medallion could be used as an award for the scientific programs as well and that it could be a permanent award, utilizable for a number of functions of the Kentucky State Medical Association. It was the unanimous recommendation of the committee that this suggestion be brought before the Board of Trustees through the Council on Scientific Assembly and Arrangements.

The committee which will judge the exhibits will be announced prior to the meeting. Judging will take place on the first day of the meeting so that proper notification of the winner can be made during the early part of the program.

A certificate of appreciation will be given to each exhibitor as in the past. These certificates will be simplified and will be printed on heavy white bond paper. It is suggested that they be signed by both the president of the Kentucky State Medical Association and the chairman of the Board of Trustees.

After considerable discussion with Mr. Meyer and Mr. Seibert, convention decorators, it was decided that there would be a change in the general construction of the exhibition area in that the burlap background would be replaced by more suitable colors and perhaps by a pegboard. The details of this reconstruction were to be worked out by Mr. Meyer in close cooperation with the visual education department of the University of Louisville of which the director, Frank Shook, is the official consultant of the Committee on Scientific Exhibits.

The committee feels that the caliber of the exhibits for this year's meeting is outstanding and was very pleased at the response to the various notices which were sent to both medical schools and to other parties prior to the deadline for the acceptance of applications.

Technical Exhibits Committee, Donald K. Dudderar, M.D., Newport, Chairman

The Technical Exhibits Committee is happy to report that all of the booth space has been sold for the 1962 Annual Kentucky State Medical Association Convention. In previous years this has not been a problem; however, this year the paramedical organizations seemed to be trimming their budgets and were not anxious to exhibit at medical conventions. This is borne out by the fact that some of the larger state medical meetings this year were unable to sell all their exhibit space. Under these circumstances, a more concerted effort may be necessary in the future to fulfill our booth commitments.

Routine letters will be sent out to all Kentucky State Medical Association members urging them to patronize the booths this year. The importance of the financial income from these companies will also be stressed to the members. As you know, the annual Kentucky State Medical Association meeting relies strongly on the financial assistance derived from the sale of booth space.

Awards Committee, William H. Bizot, M.D., Louisville, Chairman

The KSMA Awards Committee has received a number of recommendations for the various awards and has talked with a large number of members in this connection.

As you know, the Awards Committee makes nominations at the first meeting of the House of Delegates on Monday evening for the KSMA Distinguished Service Medal and the Outstanding General Practitioner Award.

Under the policy set by the House of Delegates, the committee selects the recipient of the R. Haynes Barr Memorial Award which goes to a lay person for outstanding service in public health and which is presented along with the other two awards at the President's Luncheon on Wednesday during the Annual Meeting.

Golf Committee, Harold W. Baker, M.D., Louisville, Chairman

Your KSMA Golf Committee did not meet this year because it was felt that the routine arrangements for the committee could be handled by the chairman.

Due to circumstances that developed near the end of the associational year, it was necessary to change the site of the tournament from the Audubon Country Club to the Wildwood Country Club.

As has been true in the past, in addition to the three "traveling" trophies that will be presented, we will again offer prizes on a day-to-day basis in each of the three categories.

All Kentucky State Medical Golf Association members are urged to participate. The fee of $6 covers the greens fee, associational dues and cost of the trophies. At the time this report was written, before any new fees were collected, there was $251.24 in the KSMGA fund.

Council on Scientific Assembly

David M. Cox, M.D., Louisville
Donald K. Dudderar, M.D., Newport
J. Alex Haller, Jr., M.D., Louisville
Douglas M. Haynes, M.D., Louisville
E. D. Pellegrino, M.D. Lexington
Beverly T. Towery, M.D., Louisville
G. L. Simpson, M.D., Greenville, Chairman

Recommendations of the KSMA Board of Trustees

It was moved and seconded that this report be approved in its entirety. Motion carried.

Recommendations, Reference Committee No. 2

The report of the Council on Scientific Assembly was reviewed and accepted. The committee feels that we should compliment the committee for a fine program, and recognize those responsible for it. Edmund D. Pellegrino, M.D., of Lexington was chairman of the Program Committee. J. Alex Haller, M.D., of Louisville was chairman of Scientific Exhibits Committee. Donald K. Dudderar, M.D., of Newport was chairman of Technical Exhibits Committee. William H. Bizot, M.D., of Louisville was chairman of Awards Committee and Harold W. Baker, M.D., Louisville was chairman of the Golf Committee. Other members of the Council were: David M. Cox, M.D., Louisville; Douglas M. Haynes, M.D., Louisville; Beverly T. Towery, M.D., Louisville and G. L. Simpson, M.D., Greenville.

Mr. Speaker, I move acceptance of this report. (Motion was seconded and carried.)

Report of the Council on Medical Education and Hospitals

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

> ". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * * *

The Council on Medical Education and Hospitals met three times during the associational year—December 21, 1961, April 26 and July 12. At the first and second meetings the Council discussed in detail the activities of the committees serving under the Council. Those committees are the AMERF Committee, the General Practice Committee, Hospital Committee, Committee on Postgraduate Medical Education, Advisory Committee to U. of K. and Advisory Committee to U. of L.

At the first meeting the Council had as its special guests William R. Willard, M.D., dean of the U. of K. College of Medicine, and J. Murray Kinsman, M.D., dean of the U. of L. School of Medicine. Doctor Willard is a member of the AMA Council on Medical Education and Hospitals. We feel that having the deans at the Council meetings helps establish better relations with the two schools and better communications between the AMA Council and the KSMA Council. With this in mind, we feel that the deans of the two medical schools would be an asset to the Council on Medical Education and Hospitals and therefore would like to recommend that they be appointed members of this Council.

The Council has worked on two specific activities above and beyond those of the committees during the associational year. One of these activities was referred to the Council by the Board of Trustees. The KSMA House of Delegates accepted the opinion of the AMA in regard to osteopathy. The House of Delegates referred this matter to the Board of Trustees which in turn referred it to the Council on Medical Education and Hospitals. A sub-committee was appointed to study the matter further. At the second meeting of the Council, Hollis Johnson, M.D., chairman of the sub-committee, gave a complete report in regard to this matter. The report of the sub-committee on relations with osteopathic physicians, along with a copy of the AMA resolution, was mailed to each county medical society secretary.

The other activity of the Council pertained to the establishment of a scientific achievement award to medical school faculty members by KSMA. This award is not to be given more than once a year to each school and not necessarily every year if in the opinion of the Council making the selection such an award is not justified. This Council will serve as the awarding committee. The award will consist of a medallion not to exceed $50 in cost. The medallion will be awarded at the KSMA Annual Meeting.

The reports of the committees covering their activities and recommendations follow:

AMERF Committee, Robert McClendon, M.D., Louisville, Chairman

The last meeting of the committee was on November 30, 1961, at which time a discussion of the campaign for the remainder of the year was held. One of the problems before the committee was the development of a satisfactory arrangement between the AMERF program and the two medical schools. We are happy to report that a very satisfactory arrangement was developed, after which a general mailing was sent to all members of the Kentucky State Medical Association, signed by the deans of the two medical schools and the president of KSMA. Additional hospital staff announcements were planned and personal contacts with all doctors in the large medical office buildings were instituted. County society announcements were also planned. I am happy to report that all of this was carried out and that a check for $2,118.20 was received by the U. of K. medical school from the AMERF. This was the first check the U. of K. received and in the future it will be classified as a four-year medical school and will receive its full share. The U. of L. received $9,697.57 as its portion from the AMERF. This money is a part of the $1,303,161.10 contributed by the nation's physicians during 1961. It was felt that this continued satisfactory arrangement with the two medical schools will greatly enhance future contributions of the AMERF, as well as the increased scope of the new AMERF.

Council Action: The Council on Medical Education and Hospitals accepted the report of the AMERF Committee as presented.

Advisory Committee to the U. of K., O. Leon Higdon, M.D., Paducah, Chairman

During the past year, the Advisory Committee to the University of Kentucky Medical Center has met once. The meeting was held during the KSMA Interim Meeting February 22 at Owensboro. William R. Willard, M.D., dean of the U. of K. College of Medicine, reported on the opening of the University Hospital, voluntary faculty appointments, the admission picture for the College of Medicine and Dentistry and temporary licensure for interns and residents. No significant criticisms or major problems had come to the attention of the committee members.

Council Action: It is recommended by the Council

on Medical Education and Hospitals that the report of the Advisory Committee to the U. of K. be accepted as presented.

Advisory Committee to the U. of L., Hollis Johnson, M.D., Louisville, Chairman

The Advisory Committee to the University of Louisville School of Medicine has not met during this associational year. However, we have had informal contact with the dean and the staff on several occasions.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report of the Advisory Committee to the U. of L. be accepted as presented.

Report of the Committee on Postgraduate Medical Education, Walter S. Coe, M.D., Louisville, Chairman

Since the submission of the 1960-61 report, the following activities of the Office of Postgraduate Medical Education of the Kentucky State Medical Association have been undertaken.

I. POSTGRADUATE PROGRAMS OFFERED IN THE PAST YEAR

A. PULMONARY DISEASE—A program presented at the University of Kentucky Medical Center in Lexington on October 11 and 12, 1961. Total attendance was 59.

B. RECENT ADVANCES IN THERAPEUTICS—A course presented at Pikeville on October 19, 1961. Attendance was 19.

C. OBSTETRICS AND GYNECOLOGY—A postgraduage program held at Paducah on November 2, 1961. Attendance totaled 16.

D. ANESTHESIOLOGY—Presented at Louisville General Hospital on November 9, 1961. The program attracted 19 participants.

E. THE PHYSICIAN'S RESPONSIBILITY IN THE EVENT OF THERMONUCLEAR DISASTER—A symposium presented at the University of Kentucky Medical Center at Lexington on December 7, 1961. Attendance totaled 123.

F. ENDOCRINE DISORDERS—A program presented at the University of Kentucky Medical Center at Lexington, January 24 and 25. Attendance was 48.

G. ARTHRITIS AND RHEUMATIC DISEASES—A postgraduate course presented at Norton Infirmary in Louisville on February 27, 1962. There were 36 in attendance.

H. DERMATOLOGY—A one-day symposium held at Jewish Hospital in Louisville on April 5, 1962. Attendance was 12.

I. Pediatrics—The annual postgraduate program presented at Louisville Children's Hospital from April 10 to May 29, 1962. Attendance was 115. (This does not include approximately 100 students, residents and interns and faculty who attended the conferences but did not register.)

J. CARDIOVASCULAR SURGERY—A course scheduled for presentation at the University of Kentucky Medical Center in Lexington on March 12, 1962. This program was cancelled due to inadequate advance registration and a misdirection of information between this office and the University of Kentucky. The course has been rescheduled. See II-B.

II. PRELIMINARY SCHEDULE FOR 1962-1963

A. This summer there will be a series of six conducted clinics presented at selected community hospitals around the state. Four of the sites have been chosen and they are Scottsville, Corbin, Pikeville and Shelbyville. The clinic at Scottsville will be held at 1:30 P.M. on June 20, under the direction of Edmund D. Pellegrino, M.D., Chairman of the Department of Medicine at the University of Kentucky College of Medicine; Beverly T. Towery, M.D., Chairman of the Department of Medicine at the University of Louisville School of Medicine and Harold D. Rosenbaum, M.D., Chairman of the Department of Radiology of the University of Kentucky College of Medicine. This clinic will concern itself with Problems in Internal Medicine. Doctors of the area have been invited to bring case histories, results of tests, x-rays or any other data they might have to this clinic and it is planned that actual patients will be seen.

The second clinic will be held at Corbin on June 27 and deal with Cardiology. It will be directed by John T. Reeves, M.D., Associate Professor of Medicine at the University of Kentucky College of Medicine; Leonard Leight, M.D., Associate Professor of Medicine at the University of Louisville School of Medicine and Richard Crutcher, M.D., President of the Kentucky Heart Association, Lexington. This meeting will be conducted in the same manner as the gathering in Scottsville.

The third such clinic will be presented at Kings Daughters Hospital in Shelbyville on July 25. This meeting will be conducted by Edmund D. Pellegrino, M.D., Professor and Chairman of the Department of Medicine at the University of Kentucky College of Medicine, and by Maurice M. Best, M.D., Associate Professor of Medicine at the University of Louisville School of Medicine. This program will be titled Problems in Internal Medicine.

The fourth meeting of this clinical series will be presented at the Methodist Hospital in Pikeville between August 15 and 31.

We are now waiting for date choices from the other hospitals so that their meetings can be scheduled.

B. Cardiovascular Surgery, Indications, Techniques and Results is tentatively scheduled for presentation on September 6 at the University of Kentucky College of Medicine.

C. A course in Pediatrics is planned for October of this year at the University of Kentucky Medical Center under the supervision of the Department of Pediatrics.

D. A program on Psychiatry is now in the planning stage for presentation this fall in Louisville, by the Department of Psychiatry of the University of Louisville School of Medicine.

E. The University of Kentucky, under the direction of the Department of Radiology, will present a course in X-Ray Interpretation, fall of 1962 or spring of 1963.

F. The Department of Anesthesiology of the University of Louisville School of Medicine will present a program titled "Anesthesiology—Special Emphasis for General Practitioners," on October 3, 1962.

G. Electrocardiography Interpretation will be the title of a program presented here in Louisville in the spring of 1963.

H. The one week residency course in Obstetrics and Gynecology offered at the Louisville General Hospital will continue to be offered in 1963.

I. The Department of Pediatrics at the University of Louisville School of Medicine also plans in the near future to offer a one week residency course in Pediatrics at Louisville Children's Hospital and Louisville General Hospital. This program will be limited to two students per week.

J. Frank Falkner, M.D., Acting Chairman of the Department of Pediatrics of the University

of Louisville School of Medicine, is now in the process of selecting the curriculum and speakers for a meeting to be held early in 1963 to deal with the Early Detection and Treatment of Congenital Birth Defects. This entire program will be paid for by the National Foundation and the March of Dimes.

K. The Annual Pediatrics postgraduate course will again be held in the spring of 1963, at Louisville Children's Hospital under the sponsorship of the University of Louisville School of Medicine, Department of Pediatrics.

III. PUBLICITY AND PROMOTION ACTIVITIES

A. In the past year, over 25,000 pieces of mail have been processed by the two employees of the Postgraduate Office. Of course, the major portion of this mail has been in the form of printed programs describing the courses offered. Programs are mailed to all KSMA members, to a large number of hospitals for posting on their bulletin boards, to administrators of programs in other states, and to many other persons who request them.

B. Publicity for our courses is sought through press releases sent to every daily newspaper in the state. The Louisville and Lexington papers have been very helpful. We also send notices of current meetings to the State Health Department in Frankfort in order that they call attention to them in their inter-office correspondence. News of meetings also appears in a number of other publications such as the Journal of the KSMA, the Journal of the KAGP, the Jefferson County Medical Society Bulletin, and in national magazines such as the Journal of the AMA, Postgraduate Medicine magazine and the GP magazine. We also make sure that bordering state medical associations receive this same information so that they may publish it in their own Journals.

C. Another idea devised to improve our publicity is to ask one or two doctors in each KSMA Trustee District to act as promotional agents for the Postgraduate Program. These physicians will receive advance information about courses to be offered so that they can promote the program to their fellows during the course of their work. We asked the District Trustees for their help in picking these men and they have been very helpful.

IV. CLEARING HOUSE FUNCTION

A. Our function as a clearing house for speakers has not been called on lately except by the Kentucky Academy of General Practice. We have supplied them with data on approximately 40 physicians who have spoken at postgraduate meetings held in the past. The KAGP has made good use of this information since many of these men have appeared at their seminars. This activity of the Postgraduate Office should and will be more fully publicized in the future.

B. Our precautions to prevent date and subject conflicts between various groups have been largely successful. A number of medical groups have written or called us to check availability of dates for their meetings. Our one failure occurred on November 2, 1961, when a Rural Health Conference was held at Kentucky Dam, and just 20 miles away at Paducah, a postgraduate course in Obstetrics and Gynecology was being presented. We had no knowledge that this conference was even scheduled, for if we had known we could have changed the date of our meeting. This emphasizes how important it will be for us to make strenuous efforts to learn all we can about the meeting dates and places selected for 1963.

To make our calendar of state meetings more complete, we plan to mail questionnaires to every medical group in Kentucky that we can find, asking them to provide us with all the information possible concerning their 1963 plans. We will follow up on all groups who do not reply by making a second, third, or fourth request if necessary. We will call attention to this plan in The KSMA Journal. The State Health Department will also keep us informed of their gatherings so that we may incorporate them in our listings.

V. FINANCES

A. Quarterly financial statements of the fund have been submitted regularly to Walter S. Coe, M.D., Chairman of the Committee.

B. One of our most important projects this year has been represented by our efforts to raise money to augment the existing fund. Fortunately, we have been able to do so. Our main efforts have been directed to pharmaceutical manufacturers, non-profit foundations and the Kentucky State Health Department. It looks very much as if the non-profit groups are a poor choice since most of them seem to be tied in with generally larger projects than ours. However, the pharmaceutical companies are proving easier to reach. In the period from January 1962 to June 1962, we have received grants as follows: Hoffman-LaRoche—$500, Upjohn—$500, Geigy—$500 and Smith, Kline and French—$300.

The Health Department has also been very helpful. In June we received $600 from their Division of Chronic Disease to help in our community hospital programs. Further, this same Division has promised to provide the fund with an additional $1,000 in September 1962, to pay for the presentation of not less than four days of postgraduate instruction in the field of Chronic Disease. Our request was well received in the Division of Maternal and Child Health as well. They too have pledged to make a grant to us of $1,000 in September 1962 to provide not less than four days of postgraduate opportunities in the field of Pediatrics.

The total of all the above amounts is a respectable $4,485.

C. We have also approached the voluntary health agencies. As a result of inquiries made by this office to the National Arthritis and Rheumatism Foundation, a continuation program was sponsored and paid for by them and presented here in Louisville in February 1962. This meeting was well attended by 36 doctors plus a number of interns and residents who attended but did not register. This points out, we believe, a way in which the Postgraduate Office could play a more effective part in the future by being more of a stimulating or encouraging agency to groups which are fully capable of presenting top quality postgraduate courses but have never done so because no one has asked or helped them to do so.

We have also been in contact with the National Foundation, a voluntary health organization which has recently entered the field of birth defects. We asked them if they would be interested in supporting a program here in Louisville concerning this problem. They gave us an enthusiastic approval by not only agreeing to fully support a program, but they also offered us the use of Directors of their clinical treatment and research centers as speakers. Frank Falkner, M.D., Acting Chairman of the Department of Pediatrics of the University of Louisville School of Medicine, is now working on the formulation of the program which will be presented some time in the early spring of

1963. It promises to be an outstanding meeting featuring well known and respected authorities in the field.

The Kentucky Division of the American Cancer Society also expressed an interest in becoming more active in continuing education. The society's professional education committtee expressed these ideas at a meeting with Walter S. Coe, M.D., and W. D. Harris. They are considering three ways in which this might be done. First, they are going to see if more attention can be focused on Cancer during the Annual Meeting of the KSMA. Second, they are going to study the possibility of holding a two or three day seminar of top quality and interest, featuring Cancer authorities from over the nation. Third, they have agreed to support some of our future community hospital programs. Charles E. Tucker, Executive Vice President of the Kentucky Division of the Cancer Society, will be invited to the next meeting of the KSMA Postgraduate Committee to consider further plans.

D. We have had assistance in another way as well. For over a year now the Postgraduate Program of Merck, Sharp & Dohme Co. has paid honoraria and expenses for out-of-state speakers for a number of our meetings. Unless there is a sudden change in their policy, this aid will remain available to us. The G. D. Searle Co. has also made a similar offer to us. We will certainly take advantage of the opportunities offered to us.

E. We are gratified but not satisfied with the amount of financial help that the Fund has received. Therefore, we will make every effort to increase the total in the coming year. We must point out, however, that there is absolutely no guarantee that support of any type or kind will be available to us in the next or in any other year in the future. Money will be generally available from the State Health Department, but profits and research and development costs determine how much the pharmaceutical houses can spend on special giving. We are optimistic that sources can be found.

F. Due to the very limited budget available to the Postgraduate Office, the Committee on Postgraduate Medical Education decided to charge fees for Postgraduate courses as follows: When a course is not being supported or assisted financially by some outside agency, a fee of $10 will be charged for a one-day program and a fee of $15 charged for a two-day program. These charges seem to be in line with prevailing fees assessed in other states. Conversely, when a course is being aided by financial help from some outside source, no tuition will be charged. Examples of this latter situation are the Arthritis and Rheumatic Diseases program held at Norton Infirmary in February 1962 and the Community Hospital visiting clinics.

The decision to charge fees is not an attempt to make a profit on the programs offered, but is simply an effort to replenish the fund so that additional courses can be offered.

VI. FACTS AND FIGURES ABOUT THE PROGRAM

A. Average attendance for the nine meetings presented so far this year is 49.6 persons per meeting. This represents an increase of almost 14% over last year. In an effort to stimulate attendance at future meetings and to avoid any possible misunderstanding, the Committee voted to dispense with pre-registration at postgraduate courses. It was felt that some doctors might be staying away from courses because they were usually unable to register in advance for them.

The total attendance for the year is 482 including 35 nurses, technologists, and interested lay people. The total physician attendance for the 12 months is 447.

General Practitioners accounted for approximately 35% of the total attendance. The specialties of Internal Medicine, Surgery, Radiology, and Public Health added another 35% to the total with the remaining 30% divided among the other specialties. We have also figured the attendance as compared to the number of years in practice and they are as follows:

In practice from 1 to 10 years, 28.7%
" " " 11 to 20 years, 34.1%
" " " 21 to 30 years, 24.7%
" " " 31 to 40 years, 10.2%
" " more than 40 years, 2.2%

The number of physicians who attended from each Trustee District is as follows:

District	Attendance	District	Attendance
1	11	9	15
2	8	10	98
3	11	11	11
4	62	12	19
5	113	13	19
6	17	14	24
7	26	15	7
8	6		

As a result of programs in the planning stage for the coming year, we are certain that all of these figures will again show an increase.

B. The courses presented this year contained a total of 125 teaching hours. Application was made to and approved by the Academy of General Practice for 111 of these hours to be considered as eligible for Category I Credit. We feel that this has represented an outstanding opportunity to the general physicians of Kentucky to attain their necessary credit hours. It may also be interesting to note that Kentucky doctors attended a total of 2594 hours of postgraduate instruction cosponsored by their own Postgraduate Committee in the past year. This is an impressive figure and there is no doubt that this attendance represents an up-grading of patient care in Kentucky. This total will also increase in 1962-63.

VII. OBJECTIVES FOR THE COMING YEAR

A. Since we know that steady growth is necessary, the Committee on Postgraduate Medical Education has set forth these realistic objectives which it feels can be achieved in the coming year. By doing this, the Committee is certain that educational opportunities can become more plentiful in number, higher in quality, and more important to the learning life of each member of the Kentucky State Medical Association. These objectives are listed below.

1. To work closely and cooperatively with the state's two medical schools, the Kentucky Academy of General Practice, and the Kentucky State Medical Association to coordinate postgraduate activities and planning and to act as a stimulant to those medical groups who have not entered the continuing education field as yet.
2. To publicize more fully the facilities of the Postgraduate Office in order that more physicians and medical groups take advantage of them.
3. To continue to seek new methods of effective education distribution and to carry on research in teaching techniques. As an example, we point out the community hospital visiting clinics that have already been discussed.

4. To keep in close touch with outstanding centers of postgraduate activities so that we can learn as much from them as possible. At present we are in contact with the Albany Medical College concerning their two-way radio network, and the University of Kansas and the University of California concerning correspondence courses. When these schools make new innovations, perfect old techniques or discover new ones, we will find out if they can be adapted for use in Kentucky.
5. To increase and intensify efforts to raise more money so that our operation can expand its scope.
6. To vary, whenever possible, the types of programs scheduled for presentation in order to interest and attract more participants.
7. To make a penetrating and thorough survey investigation into the wants and needs of Kentucky doctors as related to their continuing education.
8. To vigorously solicit ideas, suggestions, and criticisms of the program, so that it can be tailored to the needs of Kentucky physicians.

Council Action: It is recommended by the Council on Medical Education and Hospitals that this report be accepted with whatever suggestions the chairman might have as implementation of the plans presented.

Hospital Committee Report, James B. Holloway, M.D., Lexington, Chairman

The Hospital Committee has met on three occasions this year, January 25 and May 24 in person and by a called group phone meeting in April. A number of items were discussed. The first—a hospital accreditation or dry run plan has been put into effect and three committees, one representing Eastern Kentucky, one Central Kentucky and one Western Kentucky, have been picked. The team members are:

Eastern Kentucky: Ballard Cassady, M.D., Pikeville
O. W. Thompson, M.D., Pikeville
Western Kentucky: James Harris, M.D., Paducah
T. J. Threlkeld, M.D., Russellville
Central Kentucky: Lewis Dickinson, M.D., Glasgow
James B. Holloway, M.D., Lexington

Kenneth Babcock, M.D., Chicago, is coming to Louisville on July 12 for a meeting of this Committee to help set up what the dry run committee should look for. Somerset Hospital will be inspected some time in July or August by the dry run committee prior to their regular inspection by the American Hospital Association Joint Commission in late summer or early fall. It is hoped that these dry run committees will be of some benefit throughout the state in following years.

Secondly, a sub-committee composed of members of KHA, State Department of Health and KSMA, headed by Daniel Costigan, M.D., has been set up to go over the hospital licensing laws and suggest to the State Department of Health certain revisions which will include minimum standards for charts. This sub-committee met with Doctor Teague on June 21. The Hospital Committee recommends to the Council that the following standards for medical records be approved:

MEDICAL RECORDS AND REPORTS

1. Organization:
   The responsibility for supervision, filing and indexing of medical records shall be delegated to a responsible employee of the hospital.
2. Indexing:
   Medical records shall be properly indexed and systematically filed for ready access to properly authorized persons.
3. Ownership:
   Records of patients are the property of the institution and shall not be taken from the hospital property except by court order. This does not preclude the routing of the patient's record or portion thereof, including x-ray film, to physicians for consultation.
   Medical records shall be made available, when requested, for inspection by duly authorized representatives of the State Board of Health.
4. Content:
   Adequate and complete medical records shall be prepared for all patients admitted to the hospital or newborn delivered in the hospital. All notes shall be legibly written or typed and signed. A minimum medical record shall include the following information:
   Name and address of person or agency responsible for patient.
   Identification data (name, address, age, sex, marital status).
   Date of admission.
   Date of discharge.
   Referring and attending physicians' names.
   History and physical examination.
   Special examinations, if any, such as consultations, clinical, laboratory, x-ray.
   Provisional or working diagnosis.
   Doctor's orders, dated and signed by the physician.
   Progress notes, dated and signed by the physician.
   Nurses' notes.
   Complete surgical record signed by the operating surgeon, including anesthesia record, preoperative diagnosis, operative procedure and findings, postoperative diagnosis, and tissue diagnosis by a qualified pathologist on all specimens surgically removed.
   Temperature chart including pulse and respiration.
   Final diagnosis.
   Condition on discharge.
   In case of death, autopsy findings, if performed.
5. Physician's Responsibility:
   It shall be the responsibility of each attending physician or dentist to complete and sign the medical record of each patient as soon as practicable after discharge.
6. Orders for Medication:
   All medical records shall contain the orders for medication and treatment written in ink and signed by the prescribing physician or dentist, and if given verbally, undersigned by him upon his next visit to the institution. A record of medication administered to the patient shall be included in the record.
7. Storage of Records:
   All original records or photographs of same shall be treated as confidential and shall be stored for a minimum of 25 years and none shall be disposed of except by the approval of the State Board of Health. When a hospital ceases to operate as a hospital, either voluntarily or by revocation of license, the medical records and other required records shall be disposed of as directed by the State Board of Health. Exception to the above may be made in the case of x-ray film.

Thirdly, the matter of ownership of hospital records was discussed at some length and this is being worked out along with the Insurance Committee. The Insurance Committee's plans have been approved by this Committee.

Fourthly, the item which has taken most of the Committee's time this year, has been the Clinton County War Memorial Hospital affair. This affair was first called to our attention on April 4 at which time, at

the request of the Clinton County War Memorial Hospital group from the Kentucky Hospital Association and the Kentucky State Medical Association, the Committee journeyed to look over the hospital because Blue Cross was withdrawing. The following recommendations have been made and have been brought through the Council on Medical Education and Hospitals, through the Executive Committee of the Kentucky State Medical Association and through the Kentucky Hospital Association boards:

1. They appoint a politically non-partisan Board to assume responsibility for the complete control of the hospital prior to June 10, 1962; and that steps be immediately initiated to lease the hospital to an independently formed non-profit organization separated from the influences of the official political processes of the county.
2. That if the current administrator is to be retained, he be afforded the benefits of specific training in hospital administration.
3. They accept periodic reviews of their medical records by a committee composed of a medical records librarian, a member of the Kentucky State Medical Association and a member of the Kentucky Hospital Association.
4. That all hospital charges and length of hospital stay be brought within the accepted limits of Blue Cross experience for like communities within the state.
5. That Blue Cross and the State Health Insurance Committee (commercial plans) jointly study the health insurance of the community to determine that its citizens are receiving full value for their health care payments.
6. That no later than December 1, 1962 a committee consisting of representatives of the KSMA, KHA, State Board of Health, Blue Cross and the State Health Insurance Committee (commercial plans) review the entire hospital care program and formulate recommendations to the governing board of the hospital and the community for future action of the governing board.

Following these recommendations, they were implemented by another visit to Clinton County and a review of this situation with the doctors and hospital board and interested public spirited citizens. These recommendations are in the process of being implemented by the Clinton County War Memorial Hospital Board at the present time in an effort to keep the Blue Cross hospital carrier contract in force.

Council Action: It is recommended by the Council on Medical Education and Hospitals that this report be accepted and implemented in accordance with the suggestions presented and that, because of its urgency, early action be taken on these recommendations.

General Practice Committee, Homer B. Martin, M.D., Louisville, Chairman

Introduction of 1962 Report—The work of the General Practice Committee has not been completed for this year. As of this moment, the statewide survey of general practitioners is in progress and results will be forthcoming. This report will, therefore, necessarily be abbreviated.

Last Year's Committee Report—The report in 1961 stressed the over-all decline in the number of general practitioners nationally as well as locally. This situation remains crucial since the number of medical school graduates entering general practice is estimated to comprise only 15% of the total number. The further realization that many of these will later leave the field for various specialties accentuates the seriousness of the problem.

The 1961 committee report suggested that a questionnaire be sent to all general practitioners in the Commonwealth. The purpose of such a survey is as follows:

1. To ascertain the daily practices of today's active general practitioner, and
2. To guide the education of the future family physician in the light of these activities.

General Concepts in Present General Practice Training—At this time there is general agreement that the future family physician will require an intensive two-year training period following a broadened fourth year of medical school. There is evidence accumulating to suggest that such training will consist mainly of medicine and pediatrics.

As to the specific courses proposed, there exists little agreement. Two major viewpoints are involved; viz., those of inividuals devoting themselves to general practice and those of curricula planners in schools of medicine. But, both seek to design a program which will produce family physicians of unquestioned competence.

At present, more than a dozen pilot two-year programs are in operation in the United States. It will probably require several more years to crystallize these into a single satisfactory national program. The medical school faculties generally feel that the emphasis should be on the "family physician" since the term "general practitioner" suggests an over-all competence in one individual—an ideal which is inconsistent with the rapid accumulation of medical knowledge.

Other Programs—The preceptorship program, general practice residencies and the clinic of family practice have received very limited acceptance. All evidence points to the likelihood that family physician training in the future, whatever the final curriculum, will be accomplished within existent departments in our medical schools.

Teaching in Kentucky's Schools of Medicine—As at many medical schools, the University of Louisville has a section on general practice in the Department of Community Health. This traditional lecture series, of many years' duration, consists of eight to ten one-hour lectures given during the fourth year. These lectures treat those subjects peculiar to general practice. Various departments are served by general practitioner instructors.

The University of Kentucky will begin its third year of operation and a specific program has not been formulated in this field as yet. The efforts of its postgraduate program will become increasingly apparent, supplementing the excellent programs of the Kentucky Academy of General Practice (206 hours this year), the postgraduate office of the Kentucky State Medical Association (125 hours offered up to September 6, 1962) and the University of Louisville School of Medicine.

The large rural population of our state creates a continuing demand for general physicians. This, combined with the availability of two outstanding medical schools, indicates our role in developing the program for family practice shall be a major one.

Survey of Kentucky's General Practitioners—The Committee on General Practice designed the questionnaire to be used at its called meeting in Louisville on May 9, 1962. Mailing was effected only a week ago, as of this writing, but 200 replies (approximately one-fifth) have already been returned. Some of the items of interest winnowed from the 10,000 individual points covered are summarized in this report.

Although this is rather general, the final report will be specific as the sample will be much larger. Further, much of the data are narrative and cover meetings attended, journals read, practice pitfalls, value of drug detailing, et cetera.

Preliminary Report—General Practitioner Survey

Population	Below 2,500	2,500 to 7,500	7,500 to 50,000	Over 50,000
Average Age	43½	43½	44	41
Married	96%	95%	95%	92%
No. of Children	2½	3	3	3
Years of Practice	12½	15½	15½	13½
Solo: Partnership Ratio	2:1	2:1	5:2	5:1
Average Months Internship Training	10	9	10	10
Average Months of Residency	2	5	5	3
Makeup of Practice				
Adult Medicine	†††	††	††	†††
Infant and Child Care	††	††	††	†††
Obstetrics	††	††	††	† to 0
Minor Surgery	††	††	†† to †	†† to †
Major Surgery	0	0	0	0
Hospital Practice	†	††	††	††
Occupational Medicine	†	†† to †	† to 0	† to 0
Preventive Exams	†	†† to †	††	††
Other				
Daily Patient Load	30	30	32	34
Daily Hospital Load	4	5	7	6
Home Calls per Week	11	11	12	9
Night Calls	3½	4	4	3
G.P.s Not Making Home Calls	2%	2%	2%	2%
Hours Spent Seeing Patients per Week	50	53	55	50
Days Off Each Week	Wed. or Thurs. & Sun.	Thur. & Sun.	Thur. & Sun.	Thur. & Sun.
Days of Vacation per Year	13	16	12	11
Days Spent at Meetings per Year	8	7	8	6
Combined Meeting & Vacation per Year	3	3	2	2
Total Days Off per Year	24	26	22	19
Hours Spent Reading per Week	5½	5	4½	4½

Summary—This report was intended to provide information on the current trends in general practice training as well as a preliminary report of the survey of daily practice in the field.

The Committee requests permission of the Board of Trustees to file a supplementary and detailed report of the survey.

Supplemental Report of the General Practice Committee

This report summarizes the results of the survey conducted by the committee in July 1962. The purpose of sending the questionnaire to all Kentucky State Medical Association general practitioners was to determine the current demands of general practice so as to know the specific training needs of future family physicians.

Of the thousand men in active private general practice, 370 returned their forms completed. Thirty of the questionnaires were not used because they were incomplete (7), or the recipient had quit practice for retirement (18), or residency (5). To ascertain variations between rural and urban practices, the replies were classified according to the population of the city of residence: below 2,500; 2,500 to 7,500; 7,500 to 50,000; and over 50,000. The following, then, is a report on the 20,000 separate answers which were tabulated:

General Data—Table I

The survey shows the average age in all groups to be consistent but the median age indicates a greater number of young physicians are in urban practice. This impression is strengthened by the median years of practice. Although length of training is constant, there is a manifest tendency in the rural areas toward partnership type practices.

It would be unrealistic to expect this report to lay to rest the oft-repeated statement that "doctors don't make home calls anymore," despite the statistical evidence that these calls number in the *millions* each year. The number is impressive in all areas and the 4% or less of doctors not making home calls invariably explained their inability to do so was consequent to physical incapacities.

One other myth which may be exploded is the alleged soft life of the urban practitioner. His work week is only slightly less than his country counterpart. He sees as many patients on home calls and even more in his office. Furthermore, if the city doctor has more leisure, neither the time allotted to reading nor vacation reflects this. Choice of day off shows a diversity which has confounded meeting-planners for years. Sunday, Thursday and Wednesday are popular in that order, and sixteen of the doctors do not have any day off.

The study reaffirms the value of the professional drug representative. The overwhelming number of doctors find positive value in their services.

As to meetings attended, there is a unanimity of opinions granting first place to the KSMA Annual Meeting. Its popularity equalled that of the next two contenders—the KAGP Annual Meeting and local seminar programs combined.

Makeup of Practice—Table II

There is general agreement in all population areas of the preponderance of adult medicine, pediatrics and hospital practice. Minor surgery decreases in importance as one goes from rural areas toward the city and obstetrics does similarly, although more precipitously. Occupational medicine ranks near the bottom but major surgery unquestionably rates the anchor position.

That general practice has retained its diversity is manifest by the distribution of answers. Few indicated a limited type practice and only a handful felt their subspecialty worth mention.

Journals Read—Table III

The reading habits of general practitioners are varied but four journals predominate: *JAMA, GP, KSMA Journal* and *Medical Economics.* Repeated mention of other publications attests to the many outstanding journals extant.

Need for Further Training—Table IV

Individual interests are evident also in opinions as to the inadequacies of medical education. There is but little agreement except that more training is desirable in the common, everyday phases of general practice. The multitudinous suggestions would challenge the most imaginative curriculum planner.

Drawback to Practice—Table V

Again, a great variation in answers is manifest but certain drawbacks stand out: Lack of professional assistance, excessive patient load and insufficient time. Paper work and the telephone occupy city doctors more. Beyond these, the drawbacks reflect only the day-to-day experiences and vexations incident to a busy practice.

Summary

General practice through the years has lost little of its diversity. It remains singularly demanding and challenging. The family physician of today retains his essential community role. However, his education is made all the more difficult because of such diversity. Another factor complicating the educative process is the rapid and continuous progress achieved in all branches of medicine. Only an intensified, in-depth course of *prolonged* study can safeguard the promise of family physicians for the future.

General Data—Table I

	Total	2,500	2,500-7,500	7,500-50,000	50,000
Total Replies		108	90	102	70
Average Age		44	44½	44	43
Median Age		40	41	41	38
Marital Status					
Single		4	4	4	2
Married		101	86	95	67
Widowed-Divorced		3	0	3	1
Years in Practice					
Average		16	15	14½	14½
Median		12	14	11	10
Type of Practice					
Solo		69	58	65	52
Partnership		29	27	22	15
Group		5	5	13	2
Other		5	0	2	1
Average Amount of Training (Months)					
Internship		10	11	10	11
Residency		3	3	6	4
Number of Office Patients Per Day		32	32	32	35
Number of Hospital Patients Per Day		5	6	7	6
Home Calls Per Week		13	14	12	12
Night Calls Per Week		4	4	4	3
Per Cent Not Making Calls		4	2	3	3
Average Work Week (Hours)		52	57	55	51
Days Off					
Tuesday	21	10	7	4	0
Wednesday	105	32	27	27	19
Thursday	149	37	32	44	36
Friday	12	3	2	4	3
Saturday	23	8	5	4	6
Sunday	323	74	85	90	74
Sunday Only	55	13	18	12	12
No days off	16	5	7	3	1
Hours Reading Per Week		5	4½	4	4½
Time Off Per Year (Days)					
Total		25	27	24	23
Vacations		14	17	14	14
Meetings		8	7	8	6
Combined Vacations—Meetings		3	3	2	3
Value of Detailmen					
Best Source of New Information		9	9	14	8
Of Positive Value		80	68	76	48
No Real Value		11	12	10	12
Meetings Attended					
KSMA	236	73	59	56	48
KAGP	143	39	32	34	38
Seminars	97	35	20	18	14
AAGP	50	10	21	9	10
AMA	41	10	12	7	12
SMA	23	6	4	12	1
Tennessee Valley	12	6	2	3	1
Others	47	12	12	18	5

READING HABITS—TABLE III

JOURNALS USUALLY READ	ALL	2,500	2,500-7,500	7,500-50,000	50,000
JAMA	259	73	66	69	51
AAGP	168	44	47	38	39
KSMA	134	45	36	33	20
Medical Economics	122	39	30	31	22
Modern Medicine	72	18	23	19	12
Post Graduate Medicine	65	23	15	15	12
New England J. Medicine	59	13	9	20	17
Medical Clinics North America	56	17	11	16	12
Southern Medical	52	18	14	13	7
Archives Medicine, Surgery	31	9	5	8	9
M.D.	30	11	10	6	3
K.A.G.P. Journal	28	11	7	6	4
Other	161	32	50	41	38

Recommendation—The Committee on General Practice, from its year's efforts, concludes there is a growing awareness throughout the profession of the acute shortage of general physicians. Simultaneously, there is a trend toward developing an acceptable program which will emphasize the training of family doctors and ease this critical shortage.

To reaffirm the belief of the Kentucky State Medical Association that all the citizens of the Commonwealth deserve the highest quality care, we therefore recommend that the Board of Trustees,

1. Notify the deans of Kentucky's two medical schools of the Board's continued concern and interest in the problem, and
2. Recommend that the schools continue to strengthen and expand their sections on family practice and pursue an active course of postgraduate instruction as well as new programs to attract graduates into family practice.

Council Action: It is recommended by the Council on Medical Education and Hospitals that this report be accepted.

As chairman of this Council, I would like to take this opportunity to express my sincere thanks for the fine work and cooperation during this associational year of the committees serving under this Council.

Council on Medical Education and Hospitals

Hollis Johnson, M.D., Louisville
O. Leon Higdon, M.D., Paducah
James B. Holloway, M.D., Lexington
Robert McClendon, M.D., Louisville
Homer Martin, M.D., Louisville
Walter S. Coe, M.D., Louisville, Chairman

Recommendations by the KSMA Board of Trustees

The report, including all recommendations, was approved without dissent.

MAKE-UP OF PRACTICE—TABLE II

	Much	Moderate	Little	None	Much	Moderate	Little	None	Much	Moderate	Little	None	Much	Moderate	Little	None
Adult Medicine	59	43	0	0	50	45	1	0	40	54	2	1	54	20	2	0
Infant and Children	47	50	5	0	41	51	4	0	31	48	10	5	39	36	7	4
Obstetrics	47	15	4	16	23	43	14	16	22	36	8	30	10	24	11	32
Minor Surgery	14	54	25	7	17	48	25	5	10	41	36	11	2	30	35	8
Major Surgery	5	8	8	80	6	6	11	64	3	12	7	75	0	1	1	71
Hospital Practice	20	36	31	14	25	52	13	10	27	54	9	3	17	50	7	2
Occupational Medicine	4	10	49	37	2	30	35	28	6	16	39	35	4	18	24	30
Others:																
Anesthesia									2	3						
Geriatrics	1															
Dermatology					1				1							
Insurance		1														

TRAINING INADEQUACIES—TABLE IV

Training Needed In	2,500	2,500-7,500	7,500-50,000	50,000
First Choice	Common Office Procedures (92)	Same	Same	Same
Second	Medical Economics (44)	Same	Same	Same
Third	Obstetrics (19)	Public Relations (21)	Surgery (25)	EENT (18)

Others: Medical ethics (19), psychiatry (18), internal medicine (17), pediatrics (13), diagnosis, orthopedics (11), cardiology (11), dermatology (6), drugs (5), geriatrics (5), preceptorships (4), laboratory, anesthesia (2), urology, fluid balance, 3-year internships, and medical politics (1 each).

DRAWBACKS TO PRACTICE—TABLE V

Worst Drawback to Practice	2,500	2,500-7,500	7,500-50,000	50,000
First Choice	Lack of Professional Assistance (26)	Work Load (44)	Time Lack (41)	Work
Second	Lack of Adequate Facilities (23)	Time Lack	Work Load	Time
Third	Work Load	Lack Facilities	Insurance Papers (20) Telephone (13)	Phone

Others: location, inadequate income (11 each), lack of education, age, disability (7 each), hospital restrictions (6), patient education (5), unnecessary home calls (4), too much obstetrics, neurotics, taxes excessive (3 each), U.M.V., encroachment, too much geriatrics, political stress (2 each), unethical colleagues, not enough obstetrics, limited license, drug prices, no privacy, medicare, and "my wife" (1 each).

Recommendations, Reference Committee No. 2

Report of the Council on Medical Education and Hospitals

Report No. 11 concerns the report of the Council on Medical Education and Hospitals, Walter S. Coe, M.D., Louisville, Chairman.

The reference committee wants to compliment the Council on Medical Education and Hospitals for the great amount of work it has done this year. The council proposes that Deans of both medical schools be made members of the Council on Medical Education and Hospitals at an appropriate time.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

The *Report of the AMERF Committee* was considered and approved. The chairman of this committee is R. McClendon, M.D., Louisville.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Advisory Committee to the University of Kentucky

The Report of the Advisory Committee to the University of Kentucky, Leon Higdon, M.D., Paducah, Chairman, was considered and approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the Advisory Committee to the University of Louisville

The Report of the Advisory Committee to the University of Louisville, Hollis Johnson, M.D., Chairman, was read by the committee and was voted to be accepted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Postgraduate Medical Education Committee

The Report of the Postgraduate Medical Education Committee, Walter S. Coe, M.D., was read and accepted.

We would like to commend Doctor Coe and his co-workers for the outstanding program which they have carried out during the past year and for the objectives they have set forth for the coming year. We would urge that the headquarters staff for the KSMA do everything possible to continue the promotion of the program under Doctor Coe and his associates.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the Hospital Committee

The Report of the Hospital Committee, James P. Holloway, M.D., Lexington, Chairman, was considered and was approved. The Committee would like to commend efforts being made to improve hospital standards.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the General Practice Committee

The Report of the General Practice Committee, Homer B. Martin, M.D., Louisville, Chairman, was considered and accepted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Recommendation, KSMA Board of Trustees, Re. Postgraduate Medical Education

The Board of Trustees recommends that the KSMA Postgraduate Program be modified to that of a liaison office, which would be staffed by a part-time secretary, who would be under the direction of the Headquarters Office. This employee would continue to coordinate the schedule and promoting of meetings in cooperation with the two universities, the KAGP, the University of Tennessee, and other groups; that any change in the program would not be made until the first of the year in order to give present employees time to secure new positions and that the total outlay under the new program not exceed $5,000 a year.

Recommendations, Reference Committee No. 2

Our Committee has considered a portion of the report of the Chairman of the Board of Trustees as pertains to postgraduate medical education. The part of this report considered by our Committee includes the last paragraph on Page 16 and the first paragraph on Page 17 of Report No. 4 and includes the final recommendation of the Board of Trustees.

The Committee recognizes the very excellent work being done by the University of Louisville and the University of Kentucky Medical Schools in their contributions to postgraduate medical education. Also, we are aware that other groups have their own medical education programs. We feel that these are very beneficial to the medical profession over the state and we would like to implement the coordination of the various programs.

In consideration for the plans of the Board of Trustees, our Committee would recommend the acceptance of the recommendation of the Board of Trustees, namely that the allotment to the postgraduate program of KSMA not exceed $5,000 a year.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution G
Campbell-Kenton County Medical Society

Be it resolved that the House of Delegates of the Kentucky State Medical Association repeal the allocation of funds now used for the administration of the Kentucky State Medical Association's Department of Postgraduate Education.

Recommendations, Reference Committee No. 2

Resolution G was presented by the Campbell-Kenton County Medical Society regarding postgraduate medical education. In view of the previous action taken on this matter, the Committee recommends that this resolution not be accepted.

Mr. Speaker, I move this resolution not be accepted. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of this report as a whole. (Motion seconded and carried.)

Reference Committee No. 2

Guinn S. Cost, M.D., Hopkinsville, Chairman
K. M. Eblen, M.D., Henderson
Thomas McElhinney, M.D., Covington
Ralph Denham, M.D., Louisville
Loman C. Trover, M.D., Madisonville

REFERENCE COMMITTEE NO. 3

Melvin Bernhard, M.D., Chairman
Reports on Legislative Activities

Report of the Council on Legislative Activities

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Legislative Activities is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * * *

PART I—NATIONAL AFFAIRS

The Chairman of the *Legislative Council on National Affairs* wishes to express, on behalf of himself and the Council, his appreciation for the confidence demonstrated by allowing them to serve in this capacity and dealing with one of the most vital problems ever to face the field of medicine in the United States.

Much has been done since the report of this Council a year ago. No problems have been solved but the practitioners in Kentucky and over the nation are united as never before. They are informed and eager to approach political problems that not too many months ago they tended to shun. They have witnessed the effectiveness of united action, even against powers of the most politically potent groups in the world. They have seen that they are keystones to the protection of our government from the advocates of socialism.

The Council and Key Man Committee met six times in regular session during the year plus one three-hour session at the end of the Congressional dinner in Washington. Meetings have been attended by AMA field men who have acted to clarify issues and one 30-minute telephone conference was held between four AMA staff members and the members of the Council and Committee.

AMA-sponsored meetings on legislative problems were attended by the chairman in New York, Chicago on two occasions, Washington, and Denver. The two co-chairmen assisted in the formation and execution of plans for the President's Steering Committee. Other medical and joint committee meetings were attended in an effort to further our endeavors in the legislative field. In all about 40 days were spent by the chairman on National Affairs in the process of trying to gather and disseminate information concerning this Council.

The Council and Committee on National Affairs has had as its chief objective the preservation of the free enterprise system from individuals and organizations who are increasingly less coy in their denials of a *true socialistic intent*. The President has stated for national television consumption that the "progress" of medicine in this country is 20 years behind the countries of Europe. This roughly dates the socialization of medicine in those countries and the President has not bothered to deny the repeated charges that his only allusion was to the fact that those countries are socialized and ours is not.

At this writing, July 9, the status of H.R. 4222 has dramatically changed in that it is now before the Senate. It is in the form of a bipartisan amendment to a welfare bill, H.R. 10606, which has been endorsed by our own Senator John Sherman Cooper.

There are two aspects of outstanding importance that have transpired during the past year. *One* has been the dismal failure of the Golden Age rallies last May 20 which were to be climaxed by a nationwide telecast by the President to gather support for H.R. 4222. The attendance was poor, many of the rallies were canceled at the last moment, and the plan to present the President with a petition bearing a million signatures of aged voters did not materialize that day.

The *Second* important event was the subsequent highly dramatic television appearance of our own Doctor Annis who was able to capitalize on the opposition's propaganda and dominate the situation in such a manner as to captivate the sympathies of the nation with such finality that a subsequent Gallup

Poll revealed drastic downward revisions in the feeling in favor of the King-Anderson Bill.

It is not possible to overestimate the importance of the actions of individual physicians whose job was made easier by the appearance of Doctor Annis. It is not possible to overestimate the importance of teamwork on the county or state level. The work of state and national staffs has been inspired and dedicated. Certainly our position has improved in the past year through the efforts of thousands of men who know, beyond question, that the true aim of many of the leading "liberals" is to socialize the economy of the United States.

There are a number of bills of medical significance now before the Congress. For fear of losing track of the main issue I will not enumerate them but ask that you ask for reports from your key man who will receive evaluations of these bills in the Legislative Bulletin. It is important that we impress our legislators with knowledge and interest in legislation other than King-Anderson—we should demonstrate an interest in other medical and non-medical bills which concern us as conscientious citizens. We must show an honest, an enlightened, and audible concern for all phases of our government, including the election of legislators who we feel will vote to further the precepts in which we believe.

This brings up a third development of major importance during the past year—that is the election of Congressmen and Senators who are under fire from the President to announce their intentions regarding the placement of medical care of the aged under Social Security before election time. In Kentucky we have those who have declared one way or another, those who are unopposed and those who would rather not say anything about it. As a group which has declared its philosophy in no uncertain terms it behooves us, as men who are accustomed to acting on their decisions, to actively support, with all vigor, those candidates in November, who have taken positions consistent with the free enterprise system. If we do less than this we believe that the *Council on Legislative Activities* has no reason for existence. The accumulation of information without subsequent effective action is surely a worthless thing—the possibilities for major action are in your hands.

We are aware that there has been a political action committee formed by the doctors in Kentucky. The Council wishes to commend this young organization for the progress it has made and to encourage its further development through your active support.

A campaign for resolutions and letter writing has been a continuous project. It is known that a large number of letters and resolutions have been sent to the legislators but the headquarters has not received evidence of all of them. This is very possibly one of the most important devices we can employ to inform our representatives of the united feelings of large groups. It is very important to the association that copies of all material sent to Washington be sent to KSMA Headquarters so they can evaluate our united effort.

The annual *Washington Dinner* for Congressmen, Senators and wives and staff with the Legislative Council, Key Men, headquarters staff and wives was held in March. This was thought to have been the most successful dinner of this type. Congressman Spence was the only legislator absent—he was in the hospital undergoing examinations. Several delegations of doctors and wives visited all offices of Kentucky's congressmen and senators and discussed legislative matters of importance to the association.

Legislative Council Bulletins and special letters have been published periodically as the need arises with the contents approved by your chairmen on State and National Affairs. These bulletins and letters are mailed to all legislative key men, members of KSMA's Board of Trustees, officers, AMA delegates and specialty group consultants. To get maximum benefit from this source of information, it is expected that the county legislative key man will discuss the issues at county society meetings and perhaps post such bulletins and letters on the bulletin board in the doctors room at hospitals.

In order to further develop the position of medicine in the legislative field the *Council* recommends the following proposals:

1. The Washington dinners be conducted every two years, preferably those years involving congressional elections.
2. That the following resolutions be adopted:
   a. Resolution of gratitude and appreciation to Doctor Annis
   b. Resolution of support for all candidates who have openly announced opposition to the placement of medical care of the aged under Social Security
   c. Opposition to H.R. 10606 and any other so called compromise short of deletion of social security from bills proposing to furnish medical care for the aged
   d. Resolution stating intention of KSMA to obey the laws of the land but to oppose with all vigor all attempts to bring socialism to the United States.

PART II—STATE AFFAIRS

During the past year activity at the State Level has been more or less divided into three phases: Pre- and Post-Legislative Sessions and the Session itself.

The first phase was devoted entirely to the consideration and formulation of bills to be introduced and sponsored by KSMA. Initially they were given the following priority.

1. Immunization Bill
2. Chiropractic Bill
3. Privileged Communication
4. Emergency care at the scene of an accident (Liability)
5. Highway Safety

Since several of these bills were of interest to and (in some instances) involved the Allied Medical Services, your Chairman was directed to meet with this particular Council. On December 5, 1961, at a regular meeting of the Council on Allied Medical Services, all proposed legislation was presented and discussed. At this meeting the dentists requested that they be included in the privileged communications bill and it was so drawn, and the Legislative Council recommended its introduction.

Proper liaison was instituted with the administrative officials to study our legislative program.

Our second phase began with the convening of the Kentucky General Assembly. During the 60-day session 92 of the bills introduced had medical implication and a resumé of some of these bills is attached and made a part of this report.

During this past Legislative Session, the effectiveness of the Key Man System was demonstrated. Several times, a few phone calls, telegrams or letters produced the desired results and we were able to show many representatives and senators the true situation as we interpreted it. In our opinion, the results of the bills of interest to KSMA were extremely gratifying.

Before drafting a bill on Highway Safety, Gaines Davis consulted the Department of Safety to see what they might have in mind. He learned that they planned to introduce a bill of their own. In compliance with Mr. Davis' recommendation it was agreed that we should support the Safety Department's bill rather than try to introduce one ourselves.

A bill on Civil Immunity and Disciplinary Action was drafted by Mr. Davis at the Council's request. After due consideration it was decided that it should be given further study as recommended by the Reference Committee to the House of Delegates in 1961.

Once these bills were successfully drafted, all efforts were devoted to plans for a successful campaign.

The third phase of the State Affairs began at the end of the 1962 Kentucky General Assembly. As yet this has not ended and it will be continued by the new Council.

Our main concern now is the responsibility of promoting and conducting an educational campaign on cultists. As you will recall, this is one of the directives handed us by the 1961 House of Delegates. This Educational Campaign is now the one main concern at the State Level. Several suggestions had been made in the past meetings but as yet nothing definite has been decided, but your Council is becoming very active in this respect.

I would like to take this opportunity to express, on behalf of the Legislative Council, our deep appreciation for the wonderful cooperation and assistance given this past year by everyone at KSMA headquarters. Particularly, I wish to express my sincere appreciation to Joe Sanford in all that he has helped with in this past year.

We think the House of Delegates and every doctor in the State of Kentucky owes Bobbie Grogan a vote of thanks for all that he has done in this past year. We feel that it should be a matter of record that this individual, during the last General Assembly, represented KSMA in an extremely brilliant and wonderful way. Much that he did would ordinarily require the energy of two individuals. All that he did was performed in a very unselfish manner and always with the purpose of elevating the position of KSMA.

This report could not be closed without also expressing our sincere thanks to Gaines Davis for his wonderful cooperation and assistance during this past year.

Council on Legislative Activities

Branham B. Baughman, M.D., Frankfort
J. Duffy Hancock, M.D., Louisville
Daryl Harvey, M.D., Glasgow
Thomas Leonard, M.D., Frankfort
F. R. Scroggin, M.D., Dry Ridge
John C. Quertermous, M.D., Murray,
Chairman—National Affairs
Robert D. Shepard, M.D., Lexington,
Chairman—State Affairs

(Supplement to Report on State Legislative Affairs)
1962 Kentucky Legislative Session

During the 60-day legislative session of the Kentucky General Assembly 953 House and Senate bills were introduced of which 92 had medical implication. Forty-four of these passed both houses.

A resumé of some of these bills follows:

S. B. 28—Buckman: Amending KRS 342.020 to include compensation for *chiropractic* treatment in addition to other treatments under the Workman's Compensation Act. (Opposed by KSMA.) *Held in committee.*

S. B. 30—McCann: Requiring *safety belt attachments* on all new passenger cars sold or brought into the State after 1963. (Approved by KSMA.) *Passed and signed by Governor.*

S. B. 46—Ware: Amending KRS 212.640 to add a sixth member, who must be a *dentist,* to the boards of health in counties containing a city of the second class. (Approved by KSMA.) *Passed and signed by Governor.*

S. B. 57—Raney: Amending KRS 402.120 to exempt persons 65 years of age or older from taking a medical examination before obtaining a marriage license. (Opposed by KSMA.) *A vote was never taken on the bill.*

S. B. 101—McCann: Permitting licensed *physicians* who are members in good standing of state and county medical associations, to *practice in any hospital* totally or partially supported by public funds. (Opposed by KSMA.) *Held in Committee.*

S. B. 126—Mann: Amending KRS 161.155 to permit *chiropractors* as well as physicians to certify a teacher's illness under sick leave provisions. (Opposed by KSMA.) *Held in committee.*

S. B. 154—Duffy: Requiring *safety inspections* at least once but not more than twice each year of every *motor vehicle,* trailer and semitrailer registered in Kentucky, by privately owned franchised inspection stations, all vehicles to have been inspected by July 1, 1963; establishing inspection standards; providing for supervision by the Department of Public Safety; setting fees for inspections and for licensing of stations; amending KRS 189.730 and 189.990 to conform; repealing KRS 189.740; effective July 1, 1962. (Approved by KSMA.) Passed Senate 22-8; *Defeated in House,* 30-50.

S. B. 220—Mann: Amending sections of KRS Chapter 205 to extend benefits of medical care paid by the Department of Economic Security to include *Chiropractic* services; adding a committee on chiropractic care to the list of technical advisory committees; requiring the addition of a chiropractor to each county medical review committee. (Opposed by KSMA.) *Vote never taken on bill.*

S. B. 223—Swope: Requiring parents and guardians to have children *immunized* against diphtheria, smallpox, pertussis, tetanus, and poliomyelitis within 12 months after birth; prohibiting school entry without immunization certificate unless the parent or guardian files a written objection with the governing body of the school. (Opposed by KSMA) *Held in Committee.*

S. B. 294—Mann: Creating a State Board of Chiropractic Examiners and stipulating qualifications of its members; stating powers, duties, and method of procedure of board providing traveling expenses and per diem pay for board members; penalties for those practicing chiropractic in violation of provisions of this act; repealing KRS Chapter 312. *Passed and signed by Governor.* The bill does not change the present law other than give the Chiropractic Board more control over its own membership. KSMA attempted to amend the bill which in essence would have accomplished the passage of our chiropractor bill (H.B.553). The Senate would not permit adding amendments to S. B. 294.

H. B. 97—Hill, Roberts, Denham, A. E. Tucker, Bunnell, J. Y. Brown: Authorizing creation and incorporation of *professional service associations* by persons required to be licensed to render services; granting to such associations the same power as other corporations; allowing associations to have only one, two or three shareholders; one, two or three directors and one, two or three incorporators who shall be such shareholder(s) and fill all offices; requiring associations having more than three shareholders to have the number of officers and directors required by KRS Chapter 271; allowing the association to render services only through its licensed officers, employes and agents, and to collect fees for such services; specifying other requirements for the name of the association, consolidations and mergers, purchases and redemption of shares and certification by the president that all shareholders are licensed; exempting corporations already organized to perform professional services from the provisions of the act. *Amended in the House,* substituting the words "professional service corporation"; for the words "professional service association"; allowing such corporations to invest funds in real estate mortgages, stocks, bonds, or any other investment, or own property necessary to render such professional services. *Amended in* Senate, including confidential and ethical relationships in those exempt from alteration by the Act; requiring two, instead of one, or more shareholders' names in the corporate name; prohibiting any authorization of professional advertising contrary to ethical standards. (Approved by KSMA.) *Passed and signed by Governor.*

H. B. 115—J. Y. Brown: Repealing the tax on individually earned income; earmarking all excess revenue received from the sales tax, over and above the 1962-63 budget, to replace the tax receipts on individually earned income; amending KRS 139.050 to include the price received for labor or *services rendered in any business* in gross receipts under the sales tax definitions. (Opposed by KSMA.) Amended in House deleting the inclusion of labor and services in gross receipts under the sales tax; graduating earned income exemptions upward annually until all tax on such income is removed, as sales tax revenues increase; requiring lowered exemptions if sales tax revenue declines. *Bill did not pass.*

H. B. 146—Mills: Requiring the Department of Economic Security to promote facilities for housing care for the aged; specifying functions of the department as to the provision of assistance and information; establishing a Nursing and Personal Care Home Fund for loans to such projects; authorizing transfer of departmental monies to the fund, not to exceed $150,000 for the 1962-64 biennium. (Approved by KSMA.) *Passed and signed by Governor.*

H. B. 236—Denham, Mills: Requiring parents and guardians to have their children *immunized* against diphtheria, smallpox, pertussis, tetanus and poliomyelitis within 12 months after birth; prohibiting entry of a child into school without certificate of such immunization. (KSMA's Bill.) *Passed and signed by Governor.*

H. B. 514—Denham: Amending KRS 311.380 to define Board as the State Board of *Podiatry* instead of *Chiropody,* amending KRS 311.410 to name the Commissioner of Health as secretary of the board; amending other sections of KRS Chapter 311 to conform to changes in this act. (Approved by KSMA.) *Passed and signed by Governor.*

H. B. 553—Denham: Amending KRS 312.010 to exclude the use of drugs, x-ray or cutting instruments from the definition of chiropractic; amending KRS 312.020 to limit chiropractic which a license authorizes a person to practice; limiting advertisement by person so licensed; amending KRS 312.060 to revoke chiropractic license for willful violation of law. (This was KSMA's bill. Since S. B. 294 could not be amended, it was impossible to pass this bill.)

H. B. 573—Denham: Prohibiting the advertisement of services by persons licensed to practice *medicine, osteopathy,* or *chiropractic,* except for announcements, telephone directories, and small signs. (Approved by KSMA.) *Bill passed House but failed to get out of Senate Rules Committee.*

H. R. 43—Gaines: Concurrent resolution requesting the *motorcar industry to* incorporate in all American motorcars those devices and structures that are known to be capable of reducing the number of highway deaths and injuries. (Resolution submitted by KSMA Safety Committee.) *Passed and signed by Governor.*

H. R. 112—Fitzpatrick: Requesting the Legislative Research Commission to study and investigate the distribution and pricing of drugs. Passed by voice vote. (Opposed by KPA and KSMA) Resolution was reconsidered and killed by a vote of 35-12.

Numerous bills were backed by the State Health Department and were approved and supported by KSMA. Others were sponsored by allied medical organizations and had the medical association's support.

Recommendation of the KSMA Board of Trustees

National Affairs

The Board of Trustees reviewed this report on July 26, 1962. The report was approved unanimously.

State Affairs

The Board of Trustees reviewed this report on July 26, 1962. This report was likewise approved without dissent.

Recommendations, Reference Committee No. 3

National Affairs

Reference Committee No. 3 discussed the report of the Council on Legislative Activities, Part I, concerning national affairs, separately, and it was the recommendation of the committee that this report be accepted and implemented.

Mr. Speaker, I move the acceptance and implementation of this portion of the report. (Motion was seconded and carried.)

State Affairs

Part II of the Council on Legislative Activities, concerning state affairs, was also discussed separately. It was the recommendation of the committee that this part of the report be accepted and implemented.

Mr. Speaker, I move that this portion of the report be adopted. (Motion was seconded and carried.)

Resolution H

Campbell-Kenton County Medical Society

"Be it resolved that the House of Delegates reinstruct the Trustees to proceed with a vigorous public education program in regard to cults and to continue to press for any legislation needed to define their activities in the State of Kentucky."

Recommendations, Reference Committee No. 3

Robert Hoffman, M.D., appeared before this committee and explained this resolution.

Reference Committee No. 3 recommended the acceptance and implementation of this report with the further recommendation that the KSMA members be made reacquainted with the "Chiropractic vs. Science" pamphlet.

Mr. Speaker, I move the acceptance and implementation of this recommendation, as amended. (Motion seconded and carried.)

Resolution A

Muhlenberg County Medical Society

"WHEREAS, our senior member is in active modern practice at 80 years of age, and

"WHEREAS, we are the proud heirs of a tradition that the physician serves his fellow man as long as the strength is granted to him, and

"WHEREAS, we find the responsibility for our own material welfare a minor burden as compared to the daily responsibility we shoulder in the care for the lives of our fellow men, and

"WHEREAS, intellectual honesty requires that we be in no personal relationship of obligation to the professional advocates of socialization; therefore be it

"*Resolved,* that the Muhlenberg County Medical Society unanimously endorse the recent AMA rejection of Social Security coverage of physicians in independent practice, and be it further

"*Resolved,* that we request the Kentucky State Medical Association to publicly acknowledge support of the American Medical Association declaration."

Recommendations, Reference Committee No. 3

Resolution A was introduced by the Muhlenberg County Medical Society; subject: Endorsing AMA Action Relative to Social Security.

It was the recommendation of Reference Committee

No. 3 that this resolution be referred to the Board of Trustees for further study and implementation.

Mr. Speaker, I move the acceptance and implementation of this resolution. (Motion seconded and carried.)

Resolution B
Muhlenberg County Medical Society

"WHEREAS, the American system of individual medical care under direct physician responsibility has been under the most intense attack ever mounted by the advocates of the Welfare State, and

"WHEREAS, the mobilization of our profession to counter this threat has been the most effective ever attained, and

"WHEREAS, the recommendations of the Association to the government of the Commonwealth of Kentucky have received welcome and effective attention, be it therefore

"*Resolved*, that this Association recognize the diligent and effective efforts of our Legislative Council on National and State Affairs and of our Officers and Board of Trustees in their guidance and effective support of the legislative activities of the Association, and be it further

"*Resolved*, that this Association express appreciation for the exceptionally inspired and effective leadership provided by the Officers and Staff of the American Medical Association."

Recommendations, Reference Committee No. 3

Resolution B, introduced by the Muhlenberg County Medical Society, subject: Commending KSMA Legislative Council, Officers and Trustees.

Reference Committee No. 3 recommends that this resolution be passed. Mr. Speaker, I move the acceptance and implementation of this report. (Motion seconded and carried.)

Resolution C
KSMA Board of Trustees

"WHEREAS, the American Medical Association is the official spokesman for American medicine, and

"WHEREAS, in this capacity the AMA has properly accepted the responsibility of providing the leadership necessary to resist legislative measures of socialized medical care, and

"WHEREAS, this leadership has been vigorous, in good taste, aggressive and obviously effective; therefore be it

"*Resolved*, that the House of Delegates of the Kentucky State Medical Association go on record as expressing its lasting appreciation for the splendid attainments of our national organization; and be it further

"*Resolved*, that the House of Delegates of KSMA pledge its continued efforts to improve our nation's medical resources and pledge further its continued determination to oppose legislative measures of the King-Anderson type that would weaken or destroy these resources."

Recommendations, Reference Committee No. 3

Resolution C was introduced by the KSMA Board of Trustees, subject: Appreciation for AMA Leadership.

The Committee recommended that this resolution be passed. Mr. Speaker, I recommend the acceptance and implementation of this resolution. (Motion seconded and carried.)

Mr. Speaker, I recommend the acceptance and implementation of this report as a whole. (Motion seconded and carried.)

Reference Committee No. 3
Melvin Bernhard, M.D., Louisville, Chairman
Thornton Bryan, M.D., Cadiz
Lenore P. Chipman, M.D., Williamstown
E. C. Seeley, M.D., London
Robert L. Shuffett, M.D., Greensburg

REFERENCE COMMITTEE NO. 4

Harvey Chenault, M.D., Lexington, Chairman
Reports on Public Service and Allied Professions

Report of the Council on Communication and Public Service

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

> ". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * *

The Council on Communications and Public Service has held two meetings during this associational year. As chairman, I would like to express my appreciation to the members who have given so unselfishly of their time and talents to the business of this Council.

There are eight committees serving under the Council on Communications and Public Service: Diabetes, Emergency Medical Services, School Health, Public Health, Senior Day, Advisory to Woman's Auxiliary, Highway Safety and the Rural Health Committee.

The AMA has inaugurated a new weekly newspaper column entitled, "Health and Safety Tips From the AMA." Our Council sent out an inquiry to all the weekly newspapers in Kentucky asking if they would like to receive this authoritative health education column from the AMA. In addition, the Council sent a letter to the county society secretaries asking them to contact their local weekly newspapers as a follow-up. As a result of this inquiry, 31 weekly newspapers in Kentucky are now receiving the column.

The Council made a sample survey of 100 physicians in Kentucky, the purpose of which was to find out how many physicians were using health education literature sent out by the AMA and the KSMA in their waiting rooms. Fifty-eight of the 100 physicians replied to the survey. Of the 58, we received 23 answers saying they used this type of literature. Thirty-four did not have literature in their waiting rooms, but indicated a desire to receive it.

Over 56,000 pamphlets to be used in the fight against the proposed King-Anderson Bill were sent out during a three-month period to some 270 physicians representing nearly every county in Kentucky.

In addition, the Council has distributed the 16mm. sound film by Edward R. Annis, M.D., entitled, "Where Medicine Is Going," to approximately 35 county medical societies and lay organizations. This excellent, informative film explaining the inherent dangers in the proposed King-Anderson Bill, was shown

by these organizations to about 45 groups ranging from 10 to 200.

Complying with a directive from the KSMA Board of Trustees, this Council sent a letter to the county society secretaries suggesting that they set up a committee of three men who are well versed in the proposed King-Anderson Bill and similar proposed legislation, for the specific purpose of answering any favorable or unfavorable publicity that the medical profession might receive from the press. A suggested outline with various recommendations as to how best to write an article or letter so it will be acceptable to the newspapers, radio and television stations was enclosed along with a list of the things the editor will consider when reviewing a letter before it is used. It was emphasized that if the committee set up or organized in the county society would follow the suggested outline and review list when writing to the editor, the chances of the letter being used would be extremely good.

Our Council has been responsible for the placing of exhibits of a health nature at various meetings, shows and conferences during the associational year. Exhibits this year have been shown at the annual KEA meeting in Louisville, the Kentucky School Boards meeting in Louisville, the KSMA Annual Meeting and the Kentucky State Fair. At all times our Council has made an effort to have exhibits which would be both interesting and informative.

The Council would like to commend the KSMA headquarters office on the excellent job done on the dedication publicity and would like to go on record as expressing appreciation for the fine way the staff went about publicizing the dedication.

For the past three years the KSMA has invited all the new members of the Association to a luncheon during the Annual Meeting at which time the activities, programs and benefits of belonging to the county society, state association and the AMA were explained. Last year only 20 members out of 100 attended the luncheon. Each year attendance has been smaller. It is evident that it is becoming more important that physicians take an active part in organized medicine and an indoctrination program for all members is one way of getting members interested in state, county and national programs and activities.

With this in mind, the KSMA president asked the Council to look into the matter and see what other state associations are doing. A number of indoctrination programs from other states have been studied and discussed by the Council on two different occasions in an effort to establish a satisfactory indoctrination program for new members of KSMA. Ways of promoting an indoctrination program for new members are: on a county or state level, on a compulsory or voluntary basis.

The Council on Communications and Public Service recommends to the House of Delegates through the Board of Trustees:

1. That an Indoctrination Program be given in conjunction with the Trustee District Annual Meeting encouraging all new members in that Trustee District to attend these programs and have them repeated for two years so that all members may have an opportunity to be indoctrinated to the benefits of membership in organized medicine. The KSMA will develop a rather intensive educational program and organize a team of physicians to present these programs to members at the Trustee District meetings. It was suggested that at the end of two years, an evaluation of the accomplishments shall be made and, if necessary, then compulsory attendance be considered at that time. The secretaries of the County Medical Societies will be requested to certify when a physician has attended one of the sessions by indicating this next to the physician's name on the county society membership report.
2. In view of the poor attendance at the new member luncheon in 1961 and preceding years, the Council recommends that we discontinue the new member luncheon and invite the new members, instead, to the President's Luncheon as guests of the KSMA, have a special table for them and recognize the new members as a group.

The following reports of the committees serving under the Council are herewith submitted:

Diabetes Committee, Robert S. Tillett, M.D., Louisville, Chairman

The Diabetes Committee met on June 20, 1962 to consider plans for the detection campaign for 1962. Although there was not a quorum of members present, there were several members of the Kentucky Diabetes Association present as invited guests and the discussion at the meeting proved interesting.

Results of previous drives were reviewed, especially that of 1959, when it was noted that there was a marked increase in the number of positives. It was felt that this may have been due to the use of the Clinitron. The further use of the Clinitron machine should be explored. It is necessary to carry out an educational program among both physicians and screenees to inform both that this is a screening test and not a diagnostic one. As a screening test, a certain number of false positives are to be expected without which the yield of new diabetics would be low.

The plans for the 1962 drive were formulated along the lines of previous years' detection drives. Additional follow-up devices are to be accomplished as the follow-up on diagnosis of screening positives has been, in the past, the weakest part of the program.

Council Action: It is the recommendation of the Council that the report of the Diabetes Committee be accepted.

Emergency Medical Services Committee, William T. Rumage, M.D., Louisville, Chairman

The Emergency Medical Services Committee has met at frequent intervals in the past year. Mainly, the Committee has concentrated its attention on matters of civil defense. A number of items have been considered.

1. A list of first aid supplies has been compiled. The list was distributed to the lay public upon request. Additionally, the list was given to the Kentucky Pharmaceutical Association. They in turn plan to print and distribute the list.

2. The Medical Self-Help Training Program has been introduced in Kentucky. A meeting was held in November 1961 in Frankfort sponsored by Governor Combs. All of the County Medical Societies were contacted about the Medical Self-Help Training Program. A list was made of those counties expressing an interest in the program and they have been visited by representatives of the state health department and the KSMA. Instruction courses in the Medical Self-Help Training Program have been conducted in six counties.

3.The 200-bed civil defense mobile hospitals have been located across the State of Kentucky. Plans are being made to have a demonstration of the hospital at the Kentucky State Fair and the KSMA Annual Meeting.

4. A meeting was held with representatives of the Kentucky Flying Physicians Association to coordinate the activities of that organization with the Emergency Medical Services Committee.

5. Plans are being made to devote an issue of The Journal of KSMA to emergency medical services in times of disaster. It is hoped that this issue will serve as a permanent reference for the medical profession.

6. The Chairman has attended a meeting of the AMA Civil Defense Committee in Pittsburgh for the purpose of exchanging information with other states within our region.

The Committee recommends:

1. At this time it would appear that future committees should give serious consideration to including on this Committee representatives of the Medical Education for National Defense Program at the University of Louisville and the University of Kentucky. In this way, the activities of this Committee will be brought to the attention of the future doctors of Kentucky while they are still in school.
2. Additionally, continuously close cooperation should be maintained between this Committee and the officials of the state government responsible for disaster planning.

The Chairman wishes to take this opportunity to publicly express his thanks to the members of the Committee, the staff of the Association and the State Department of Health.

Council Action: It is recommended that this report be accepted.

Public Health Committee, Delmas M. Clardy, M.D., Hopkinsville, Chairman

In 1957 this Committee set for its objective five specific projects in addition to its routine function of promoting Immunization Week, etc. A brief review of the overall efforts, results and comments will be given.

1. Compulsory Immunization for polio, pertussis, diphtheria and tetanus became a law in the 1962 State Legislature. Cooperation and coordination of efforts of the KSMA and the Public Health Service will be needed to iron out some of the difficulties that are certain to be encountered in administering the new law. Our efforts will be rewarded by the eradication of disease and will help restore the public image of the physician to its proper level.

2. The prevention of highway accidents. This project has been given to a separate committee which is making rapid progress in forming a program which is to be coordinated with other agencies and committees on a large scale.

3. Fluoridation of public water supplies is progressing, but too slowly. It seems that great controversy arises when fluoridation of municipal water is publicly proposed and when a referendum is carried out, fluoridation is always defeated. This Committee is of the opinion that fluoridation could and should be accomplished by other means. Universal fluoridation is urgently needed because dental health remains the greatest single health deficiency.,

4. Carcinoma of the uterine cervix is thought to be, by excellent authorities, a preventable cause of death by means of early diagnosis with the aid of the "Pap smear" and biopsy. This information is well disseminated and it is believed in time, the results of the physician's efforts will be apparent.

5. Primary bronchogenic carcinoma is the last, but not the least, of the five items of special interest to this Committee. We feel that death from a preventable disease from one cause is just as tragic as from any other cause. The role of the physician includes the practice of preventive medicine and his responsibility here is clear and evident.

In 1959, this Committee made a report with recommendations concerning this rapidly increasing disease. This part of the report was not only ignored, but was deleted from the records. We ask that this not happen again. Since that report in 1959, 100,000 deaths from primary bronchogenic carcinoma have occurred in the United States, 1,500 of these in Kentucky. There were 538 deaths in Kentucky in 1960 from this cause and in 1962 there will be no less than 600.

At its meeting on March 8, 1962 the Committee made the following recommendations:

1. The Health Commissioner requested the cooperation of the physicians of the State to start a program whereby everyone would receive the oral polio vaccine at the same time.
2. That the KSMA disseminate and assist in dissemination of the available facts concerning primary bronchogenic carcinoma and to assist in studies or surveys that might be made.
3. That a seminar on bronchogenic carcinoma be included in the scientific program of an Annual Meeting, perferably in the 1962 meeting.
4. That alcoholism is becoming a foremost health problem, with 60,000 alcoholics in Kentucky. The physician again may have some responsibility.

Council Action: It is recommended that the report of the Public Health Committee be accepted as presented.

Senior Day Committee, Carl Cooper, Jr., M.D., Bedford, Chairman

On March 19, 1962 the Annual Senior Day Program of the KSMA was held in Louisville. The opening session was held at the Rankin Amphitheatre, Louisville General Hospital. The afternoon and evening sessions were held at the Medical Arts Building.

It is the feeling of the Chairman that this Senior Day Program was as good, if not better, than those preceding it. The KSMA is deeply indebted to the University of Louisville School of Medicine and the Jefferson County Medical Society for their support and contributions to the program.

The speaker of the evening session was Hebbel E. Hoff, M.D., Professor of Physiology, Baylor University College of Medicine. Doctor Hoff did an outstanding job.

The questionnaires which were given out to the senior students to be returned have not been tabulated and this should give us at a later date, a better idea as to how we may improve the Senior Day Program.

In addition to the speakers for Senior Day, each senior student was presented with a copy of the editorial from *MD Magazine*, "To Be A Doctor." They were also given copies of an article from *Medical Economics*, "A Start-A-Practice Reference Shelf," consisting of titles pertaining to the establishment and perpetuation of a sound medical practice. The students were also given a list of equipment which would be recommended for the setting up of practice.

It was again an honor and a privilege for the Chairman to participate in this Eighth Annual Senior Day Program. I would like to take this opportunity to thank all the members of the Committee and all those who assisted in any way.

Council Action: It is the recommendation of the Council that the report of the Senior Day Committee be accepted.

School Health Committee, Richard E. Davis, M.D., Central City, Chairman

The first official activity of this Committee during this year was on October 14, 1961, when the West Kentucky Athletic Injury Prevention Conference was held at Bowling Green. William Crowdus, Franklin, President of the KHSAA, presided over this meeting of coaches, principals and teachers in the general Bowling Green vicinity.

Talks were given on athletic injuries and their prevention by O. B. Murphy, Jr., M.D., Lexington, and George M. Gumbert, M.D., Lexington; the importance of physical fitness was discussed by John L. Wolford, M.D., Louisville. Following presentation of these papers, a panel discussion, with audience participation, was held. There seemed to be considerable enthusiasm among the audience over this type of program.

Attendance was considered to be very good. The KHSAA seemed particularly pleased that one of their people presided over this meeting. Your chairman was present in an unofficial capacity and enjoyed the program thoroughly and thought that it was well presented.

Letters of appreciation were sent to J. P. Sanford from W. H. Crowdus, Ted Sanford and from Jimmy Feix, all congratulating the KSMA for its fine program at Bowling Green.

In order to be better informed, your Chairman attended the seminar at Denver, Colorado, in connection with the AMA meeting on November 26, 1961. This was the Third National Conference on the Medical Aspects of Sports. This was a well attended and informative meeting.

The first scheduled meeting of the School Health Committee was held on January 18, 1962, in Lexington. Ted Sanford, Commissioner, Kentucky High School Athletic Association attended the meeting. A discussion was held relative to the Third National Conference on the Medical Aspects of Sports at Denver, Colo. In summary of this, it was felt that the physicians in the State Association should be more aware of the problem of preventing injuries or, should they occur, in instituting proper treatment. It is hoped that an educational program will be soon initiated. Ted Sanford stated that the KHSAA Board had voted to cooperate with the KSMA in sponsoring a number of athletic injury prevention conferences around the state. The KHSAA will write to the people involved and arrange dates. Suggested locations are Murray, Western State College, Morehead, Harlan County, University of Kentucky, Louisville and Eastern State College. (It was later decided to request an additional conference to be held at the Cumberland extension of the University of Kentucky.)

In order to determine the best method of finding out which doctors in Kentucky are interested in athletic medicine, letters were sent to the county society secretaries.

The subject of initiating some form of postgraduate study or course on athletic injuries has been discussed with the Dean of the University of Kentucky Medical Center. Nothing definite has been worked out on this to date.

Correspondence was received from the Campbell-Kenton County Medical Society which appeared to be chiefly concerned about possible medical legal complications which may be encountered during active participation of physicians in rendering first aid or team care in connection with the athletic program in Kentucky. This was referred to the KSMA attorney.

At the request of Ted Sanford of the Kentucky State High School Athletic Association, an article was submitted to the Kentucky State High School Athletic Association which was published in their journal.

The second scheduled meeting of this Committee was held on April 5, 1962.

The editor of a pamphlet entitled "Medicine in Sports News-Letter," published by the Rystan Company, requested a list of Kentucky physicians interested in athletic medicine so they could make this newsletter available to them. A letter was sent to the editor including the names of physicians who have expressed an interest in athletic medicine, and asked the editor to put their names on the mailing list to receive the "Medicine in Sports News-Letter." The Committee was informed that, at the February 21 meeting of the Board of Trustees, approval was given for a series of at least five, and not more than seven regional Athletic Injury Prevention Conferences on a state wide basis. Your Chairman was much encouraged by the attitude of the Board of Trustees, and the manner in which they gave their whole support to these conferences.

Lee Gentry, Supervisor, Health Safety and Physical Education, Department of Education, Frankfort, requested that the KSMA could assist in getting expanded physical education programs in Kentucky, if KSMA would come out with a formal resolution or statement endorsing the need for physical education of our Kentucky youth. In accordance with Mr. Gentry's request, a resolution on physical education was drawn up which should have been presented to the 1961 session of the House of Delegates. Because of oversight, however, it was not presented to the House of Delegates.

We learned from Mr. Gentry that the Department of Education is trying to follow the program outlined in the booklet, "Youth Physical Fitness," published by the Superintendent of Documents, Washington, D.C. Mr. Gentry is quite eager for us to take a firm stand on this. The Committee recommends to the House of Delegates through the Council on Communications and Public Services strong endorsement of the Youth Physical Fitness Program as outlined in the booklet, "Youth Physical Fitness." A resolution has been drafted by the committee for presentation to the 1962 session of the House of Delegates. The Committee was informed that it had been requested to present a program, if possible, on Athletic Injuries at Owensboro-Daviess County High School at the request of the "Big Eight."

On April 27, 1962, a conference on the Medical Aspects of Sports was held at the Owensboro-Daviess County High School auditorium. Participating in presentation of the conference was Ralph Genito, coach of football at Owensboro Senior High School; B. H. Warren, M.D., and John F. Oldham, M.D., of Owensboro; Dr. Don Newsom, dentist, of Owensboro; O. B. Murphy, M.D.; and George Gumbert, M.D., of Lexington; and your Chairman. Attendance was better than expected. This was an ideal type of conference from the standpoint of determining what could be done quickly in developing a program providing local, as well as out of town speakers for a community. All those present in the audience seemed to be extremely interested and extremely appreciative. The response of those attending, such as Mr. Wheeler and the coaches from that area, was most encouraging.

The Committee discussed the School Health Council, but no action was taken.

Prior to the third meeting of this Committee, a request was made by Ted Sanford of the Kentucky High School Athletic Association for a program to be presented at the Fourth Annual Athletic Injury Prevention Conference August 11 in Lexington in conjunction with the annual coaches clinic sponsored by the University of Kentucky. This program has been drawn up and presented to Mr. Sanford. It was felt that there should be dental representation on this program, as well as in other programs, in order to emphasize the importance of mouth guards in body contact sports, particularly football. It is the belief of the members of this Committee that the importance of *properly* fitted mouth guards is a subject that will probably require considerable education among the coaching personnel.

Ted Sanford was invited again to meet with us on June 14, 1962, at our last meeting. He was unable to attend himself, but sent his representative, Mr. Mansfield, Assistant Executive Secretary in his office. This Committee has arranged for an Athletic Medicine Symposium at the Annual Meeting which should last one and one-half hours in duration. This committee has also arranged for an exhibit at the Annual Meeting.

Plans were discussed with Mr. Mansfield as to times and dates of regional conferences to be presented in the locations discussed at our first meeting in January 1962. Dates and places for these conferences have been arranged.

The Committee discussed on three different occasions the planning of meetings for physicians for further education in order that the ideal situation of Athletic Injury Conferences being presented locally in the various counties by local physicians could soon

be done. This will undoubtedly require a good deal of planning and work for the near future.

Council Action: It is the recommendation of the Council that the report of the School Health Committee including the resolution on Physical Education be accepted.

Highway Safety Committee, Arthur H. Keeney, M.D., Louisville, Chairman

Since the first pilot meeting of this Committee, April 6, 1962, there has been a tremendous change in working relations between Kentucky physicians and the Department of Safety. Effective avenues of rapport have been opened and medical thinking has become, for the first time, a part of statewide safety planning. Specific achievements have been:

(1) Appointment of three physicians to serve on the Governor's Safety Advisory Committee.
(2) Scientific exhibits by Kentucky Department of Safety at 1961 and 1962 KSMA meetings.
(3) Sponsored open (monthly) meeting of Louisville EENT Society (October 19, 1961) with Department of Safety to outline sensory standards for licensure.
(4) At-cost sale of nearly $2,000 worth of seat belts to members of KSMA at Annual Meeting and at Jefferson County Society meetings.
(5) Passage of House Resolution No. 43 on introduction by members of both parties in each House, strongly calling on motor car manufacturers to incorporate long-known safety devices in all vehicles. The implication of this "Kentucky Resolution" created much reaction among auto builders.
(6) Organizational meeting and dinner for Department of Safety and Cornell Automotive Injury Research team April 3, 1962.
(7) All-day conference with Ford safety engineers and public safety staff at Dearborn, April 26, 1962.
(8) Conference at Police Academy, June 23, 1962, on medical factors in driver limitation and June 7, 1962, on simplification of visual screening tests and reduction in presently high rate of over-referrals.
(9) Appointment May 8, 1962, of Advisory Committee on Highway Safety by the Legislative Research Commission. Sixteen-man membership includes six KSMA members. Remainder are all distinguished, public spirited leaders without selfish interests. This Committee will coordinate all legislative steps in the highway safety field and work closely with the Department of Safety staff. Productive first meeting held June 26, 1962.
(10) Establishment of "Kentucky-Cornell" Automotive Crash Injury Research Program to be activated in first of six sampling areas and periods on August 1, 1962. This is in close coordination with the Division of State Police, Kentucky Hospital Association and the Department of Health. Study will continue two or three years.
(11) Medical outlining of "Driver Limitation" as a reportable disease and health hazard under KRS 211.180. This establishes a modus operandi for the State Police to eliminate drivers with physical or mental disability, as they are charged under KRS 186.440. This has been verbally approved (December 13, 1961) by both the Commissioner of Health and Commissioner of Safety. The Legislative Research Commission is currently analyzing legality and methods for making this concept operative.
(12) Establishment of a KSMA Award for any social, professional, or other major civic group attaining 100% seat belt usage.
(13) Full cooperation with Ashland Oil Company program of seat belt installation at cost which has now protected 8,200 additional Kentuckians and placed 20,000 seat belts in retail stations.

The Committee requests:

(1) Favorable consideration of two additional members on this Committee:
John Robbins, M.D., urologist, Louisville
Claude Wilkes Trapp, M.D., ophthalmologist, Lexington.
(2) The purchase by KSMA of seat belts for personal cars of each KSMA employee not so protected.
(3) Council approval of the program as instituted and pursued to date.
(4) Council authorization to continue along these general lines.
(5) No additional funds but the disbursement of $120 to the Chairman for secretarial and travel expenses.

The Committee will be pleased to receive additional suggestions from the Council, Trustees, members of the KSMA or interested individuals with sincere concern for the current Kentucky highway mortality rate of approximately 15 a week and morbidity rate of approximately 400 per week.

Council Action: It is recommended that the report of the Highway Safety Committee including the Resolution Regarding Automotive Safety be accepted as presented and that the portion dealing with funds be referred to the Budget Committee.

Woman's Auxiliary, Hays Threlkel, M.D., Owensboro, Chairman

This Committee has not met during the past year. They have done a good job in the fight against King-Anderson through the use of the Ronald Reagan record "Operation Coffee Cup" and letter writing. Numerous letters have been written by the Woman's Auxiliary.

Council Action: It is recommended that the report be accepted and that we express our appreciation in a letter to the Auxiliary for the tremendous amount of work they have done.

Rural Health Committee, M. B. Denham, M.D., Maysville, Chairman

The 1961 Rural Health Conference was held at Kentucky Dam Village in November 1961. The attendance was extremely gratifying and the program was well accepted by those present. Nathan Canter, M.D., of Owensboro, served as the chairman of this conference and he is to be highly complimented on a job well done.

At a meeting of the Rural Health Council, James C. Salato, M.D., Columbia, was elected chairman of the Rural Health Council which will hold a Conference at Cumberland Falls State Park, October 25, 1962. Doctor Salato had several meetings with the program committee and the program is practically complete. Bob Johnson of the University of Kentucky Medical School is serving as chairman. Three of the outstanding speakers who have accepted an invitation to speak at this meeting are, Governor Bert Combs, Dean William R. Willard and John Whisman.

The Kentucky State Medical Association had representatives at the Regional Rural Health Conference Midwest States at Des Moines, Iowa, May 18-19, 1962. Those attending were M. B. Denham, M.D., Chairman of the Rural Health Committee, James Salato, M.D., Chairman of the Rural Health Conference, and Bobbie Grogan of the KSMA headquarters office. The speakers were outstanding men of their field from all over the nation. The theme of this regional conference was "Good Rural Health—Our Nation's Wealth." The program was well received by all those in attendance. Edmund K. Yantes, M.D.,

Wilmington, Ohio, this region's Council member, was a leading figure in this conference.

The chairman of the Rural Health Committee has met on four occasions with the Kentucky Agriculture Council as a representative of the KSMA Rural Health Committee. One of the great accomplishments of this Agriculture Council has been the establishment of a Science Center at the University of Kentucky.

This Committee wishes to encourage better attendance by physicians at the Rural Health Conferences since we are the guiding organization in these conferences. Our attendance can do much to continue to improve our relationship with the other coordinating organizations that make up the Kentucky Rural Health Council.

Council Action: It is recommended that this report be accepted.

The Council on Communications and Public Service would like to especially commend the committees that have served under this Council for their work during the associational year.

Under the Bylaws of the Association, this Council is charged with supervising and directing all associational activity in the fields of public relations and service.

Council on Communications and Public Service

Carl C. Cooper, M.D., Bedford
Richard E. Davis, M.D. Central City
Mitchel B. Denham, M.D., Maysville
William T. Rumage, Jr., M.D., Louisville
Hays Threlkel, M.D., Owensboro
Robert S. Tillett, M.D., Louisville
N. Lewis Bosworth, M.D., Lexington, Chairman

Addendum to the Report of the KSMA Committee on Public Health

Since the report of the Committee on Public Health to the Council on Communications and Public Service, events have made necessary this supplemental report.

Two or three years ago funds for venereal disease control in Kentucky were curtailed and as a result there has been a great increase in venereal disease rates, especially in three or four sections of the state. The United States Public Health Service has seen fit to resume the control program and asks assistance from the physicians of Kentucky. Without going into great detail, they ask the KSMA to approve and implement the following recommendations:

1. That if the Medical Schools in Kentucky do not give sufficient instruction in venereal disease, please intensify the program. It is felt that many physicians have graduated in the last 10 years that have never seen a primary lesion of syphilis.
2. To include venereal disease, especially syphilis, in the programs of postgraduate education. A staff of well-informed physicians is available at no cost for seminars and medical society programs on this subject.
3. That each physician increase his awareness of infectious syphilis, to suspect it and look for it. Also to make the maximum use of the U.S.P.H. epidemiologic service. Request information and assistance if such is needed. It will be gladly given.

Recommendations, KSMA Board of Trustees

This report was approved in its entirety, without dissent, except as follows: Item 2, page 18, relating to the purchasing of seat belts for KSMA employees.

Recommendations, Reference Committee No. 4

Report No. 14, the Council on Communications and Public Service, contains the reports of the Diabetes Committee, Robert S. Tillet, M.D., Louisville, Chairman; the Emergency Medical Services Committee, William T. Rumage, M.D., Louisville, chairman; Public Health Committee, Delmas M. Clardy, M.D., Hopkinsville, chairman; Senior Day Committee, Carl C. Cooper, M.D., Bedford, chairman; School Health Committee, Richard E. Davis, M.D. Central City, chairman; Highway Safety Committee, Arthur H. Keeney, M.D., Louisville, chairman; Woman's Auxiliary to KSMA, Hays Threlkel, M.D., Owensboro, chairman and the Rural Health Committee, M. B. Denham, M.D., Maysville, chairman.

This report consisting of its over-all activities and its recommendations for the indoctrination program for the new members of KSMA was considered in detail.

Reference Committee No. 4 recommended that the report, including the addendum, be accepted with the exception of the portion relating to the indoctrination program which it is recommended be returned to the Council. The Reference Committee felt that this program could be improved by making the new member indoctrination compulsory at a state level.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the Council on Allied Professions and Related Groups

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * *

During this associational year, the Council on Allied Professions and Related Groups has held two meetings, one May 3, 1962, and the other July 18, 1962. At the first meeting the Council discussed the functions and activities of the committees serving under the Council. The second meeting was devoted to hearing the reports from the various committees assigned to this Council.

Submitted below are the reports of the committees serving under this Council:

Blood Banks Committee, Marion F. Beard, M.D., Louisville, Chairman

This Committee has not met in the past year and has not had any specific material referred to it. However, there is one aspect that has arisen in the past year which this Council and the Board of Trustees should recognize.

The American Association of Blood Banks has set up a blood banks inspecting service. The blood banks of two hospitals in the Louisville area, St. Joseph and St. Elizabeth, have been inspected. The Blood Banks Committee would recommend to next year's commit-

tee that it promote and encourage the inspection service of the American Association of Blood Banks of all hospitals in Kentucky. The state should recognize this service and encourage its development in the state.

The inspections are performed upon invitation only. An excellent job is presently being done. The state inspector is Dwight Kuhns, M.D., Miners Hospital, Harlan. A request for an inspection should be referred to Doctor Kuhns.

Blood bank inspection is not included in inspection for hospital accreditation.

Council Action: It was recommended to accept this report as presented.

Infant and Maternal Mortality Committee, William H. Parker, M.D., Owensboro, Chairman

As chairman of this Committee, we have been having a meeting about four times a year or one meeting every three months. At these meetings we attempt to review, discuss and classify every maternal death up to one year preceding that meeting. Our objectives are to determine whether or not the death was preventable. If preventable, we comment on the way the case was handled, and try to decide what factors made it so.

We want to know the following things about a preventable death. Was it the patient's fault through neglect of herself, her family's fault through neglect of the community or welfare agencies, fault of the physician or the hospital? When once the fault is decided, we then seek remedial measures. We always try to stress the point that we are not a policing agency, but are seeking always to help prevent a recurrence of a similar tragedy. When we feel that the hospital or physician may have been directly or indirectly at fault, we notify the institution or individual, but always try to exercise extreme diplomacy in doing so.

In evaluating our work, I would say our progress has been slow, but reassuring. For example, we are getting more deaths reported now than we had three or four years ago, but we do not consider this an indication of an increase in our death rate. It is an improvement on getting deaths reported. There has also been an improvement in the information received from the medical profession and hospitals. We also think there has been an improvement in the over-all care given these patients. As a whole, the doctors throughout the State have been most cooperative and if there is criticism on their part, it has not come to my attention.

Council Action: It is the recommendation of the Council that this report be accepted.

Industrial Medicine Committee, Leslie Van Nostrand, M.D., Louisville, Chairman

The Industrial Medicine Committee has not met this year. My enforced inactivity was due in part to the fact that I have had to work without an associate this year in my industrial practice, this plus my outside work with the Louisville-Jefferson County Committee on Alcoholism has taken most of my time.

We plan to discuss possible projects and items of interest for the Industrial Medicine Committee at our Kentucky Industrial Medical Association meeting this fall.

I have made some tentative plans to try to attend the annual AMA Congress on Occupational Health meeting in Boston this fall. If I am able to get to that meeting and the meetings of the chairmen of the Industrial Health Committees of the state medical societies, I am certain that I shall have something more to offer in the way of constructive help to next year's chairman of the Industrial Medicine Committee of KSMA.

Council Action: It is recommended to accept this report as presented.

Tuberculosis Committee, Shelby Hicks, M.D., New Castle, Chairman

The Tuberculosis Committee feels that tuberculosis in Kentucky is a very serious problem, inasmuch as only the state of Arizona has a higher TB mortality rate than Kentucky. At the present time the Kentucky mortality rate is approximately twice that of the national average and there were 1,257 new cases in 1961 in Kentucky. Partly due to this pressing problem in Kentucky, a state wide Conference was held in Lexington on May 3-5, 1961, which was the first Conference ever held in Kentucky devoted solely to tuberculosis. Approximately 25 persons, all experienced in the field of TB, were present and this group made a report on their findings and recommendations as concerns tuberculosis.

It is the thinking of the Tuberculosis Committee that this report covers the field and area very well and that, rather than working up a separate report, the findings of this Conference in Lexington should be presented to the KSMA House of Delegates for their endorsement.

The Tuberculosis Committee of the Kentucky State Medical Association would, therefore, recommend that the following report as modified be accepted and endorsed, in principle, by the KSMA House of Delegates:

FIRST KENTUCKY TUBERCULOSIS CONFERENCE RECOMMENDATIONS

Preamble

Tuberculosis has long been and is now a primary health problem in Kentucky. Few other states have suffered the ravages of this disease in a greater extent.

By use of methods and techniques now at hand, the control of the tuberculosis problem in Kentucky within this decade is now possible.

Through the discovery and development of now unknown, but more effective, methods and techniques, the eradication of tuberculosis may well be possible. With this hope, we set as our ultimate goal the complete eradication of tuberculosis in Kentucky.

Imaginative but practical planning, followed by bold and decisive action, will ensure the attainment of this goal. Such planning and action should be both intermediate and long-range in nature, sufficiently flexible to permit immediate adoption or adaption to the hoped-for and anticipated improved methods and techniques as they may become available.

In the light of existing approved methods and techniques, the following methods are urged for immediate implementation.

I. TREATMENT

UNTIL AN EFFECTIVE VACCINE IS FOUND, ADEQUATE TREATMENT MUST BE CONSIDERED THE BEST MEANS OF CONQUERING TUBERCULOSIS.

GOAL: It is recommended that all known cases of tuberculosis be placed under effective treatment with provision for the continuity of comprehensive medical care from the time of detection to complete rehabilitation.

Therefore, the Conference recommends that emphasis be placed on the following points:

(1) Initial hospitalization of tuberculosis patients to insure adequate diagnosis, determination of appropriate treatment and education of the patient to his disease and treatment program.

(2) With current treatment methods, shorter hospitalization can be anticipated and earlier discharge encouraged provided the cooperative patient can be selected and adequate follow-up care can be insured.

(3) Clinically suspicious tuberculosis on X-ray examination, despite negative cultures for the tubercle bacilli, should be treated if the tuberculin skin test is positive and such conditions as cancer, pneumonia and fungus disease have been ruled out. Persons

known to have tuberculin conversion may and children under six with positive tuberculosis should have antituberculous chemotherapy.

(4) If, despite all persuasive measures, an infectious tuberculosis patient refuses hospitalization, the patient should be isolated as a public health measure. Unless such isolation can be effected in the community, these recalcitrant patients should be referred to tuberculosis detention wards. It is expected that only the rare infectious or contagious tuberculosis patient will fall into the latter category.

(5) In exceptional circumstances, when tuberculosis patients cannot be hospitalized, diagnosis and treatment of the patient may be carried out on an ambulatory basis provided that an adequate diagnostic and treatment program can be instituted and maintained.

(6) Anti-tuberculosis chemotherapy should be supplied gratis to those medically indigent patients leaving the tuberculosis hospital prior to an acceptable medical discharge provided that the supervising hospital physician considers the patient a good candidate for treatment on a self-administration basis. However, such chemotherapy should only be continued when the physician in charge of the ambulatory treatment program concurs in the evaluation of this patient's fidelity to the prescribed treatment.

II. CASE DETECTION

IF MODERN TREATMENT IS TO WIPE OUT TUBERCULOSIS IN KENTUCKY, IT IS APPARENT THAT EVERY UNKNOWN CASE MUST FIRST BE FOUND.

GOAL: It was agreed that the case detection program should be intensified until every single undetected case of tuberculosis is identified.

Therefore, the Conference recommends the following:

(1) Examination of all known contacts.

(2) It was recommended that all hospitals in the State of Kentucky establish a tuberculosis screening program which would include a 14 x 17 chest film or a 70 mm. chest film on all admissions over the age of 14 and tuberculin skin testing be done on all children under the age of 14.

(3) A concentration of screening surveys with special emphasis on high-incident groups.

(4) Mandatory tuberculosis case detection examinations which include tuberculin skin testing and appropriate X-ray examinations should be required for admission to public schools, for recipients of welfare help, institutionalized individuals, and recipients of care for the medically indigent.

(5) Provide additional nursing personnel or special staff to do tuberculosis follow-up work. Such personnel would work out of the tuberculosis hospital in each hospital district.

(6) Provision of free tuberculin testing materials to private physicians throughout the State in order to facilitate their use and to increase the awareness of the private physicians of tuberculosis.

(7) Encourage private physicians to submit sputums on more of their patients by providing sputum containers for their use, to be sent to the State Department of Health for examination.

(8) Several methods for increasing the complete reporting of tuberculosis were suggested. They include:

(A) All positive smears and cultures for tuberculosis which are performed in private hospitals or laboratories should be reported to the Health Department.

(B) All patients with tuberculosis treated by private physicians should be reported to the Public Health Officer.

(C) Autopsied cases with evidence of active tuberculosis should be reported to the Health Department.

(D) Medical record room librarians should report all new cases of tuberculosis diagnosed in the hospital to the Health Department.

(9) The follow-up of patients must be improved and it was recommended that this might be accomplished by obtaining additional personnel such as a professional practical field worker.

III. EDUCATION

EDUCATION IS THE KEY FOR THE DETECTION OF AND PLACING UNDER TREATMENT EVERY EXISTING CASE OF TUBERCULOSIS AND ENSURING THAT COMPLETE FACILITIES AND SERVICES FOR THE CONTROL OF TUBERCULOSIS ARE PROVIDED.

GOAL: To intensify and make use of all known methods specifically designed to reach the particular group of people approached.

Therefore, the Conference recommends the following:

(1) Education of the patient, his family, and the community about tuberculosis. This should make use of methods specifically designed to reach the particular group of people approached.

(2) The active encouragement and promotion of school health education.

(3) The active encouragement and promotion of public responsibility for the support of social and educational services aimed at the elimination of tuberculosis.

(4) The development of an outline of treatment to be published in professional journals.

IV. TRAINING

THE SUCCESS OR FAILURE OF THE CONCENTRATED ATTACK UPON TUBERCULOSIS WILL DEPEND UPON THE SKILLS AND KNOWLEDGE POSSESSED BY THOSE DEALING WITH THE PROBLEM.

GOAL: To provide an opportunity for the learning of the most modern techniques, procedures, and concepts in the diagnosis, treatment and rehabilitation of the tuberculosis patient.

Therefore, the Conference recommends the following:

(1) That there be a personnel-training program dealing with the problem of tuberculosis. This program should include workers in public and private agencies rendering assistance to the individuals and families, such Divisions as: The Division of Economic Security, Department of Welfare, Child Welfare, and family services agencies.

(2) A new position for public health personnel be established. These sub-professional workers would provide the assistance needed to carry out the intensive diagnostic, treatment, and educational program which the physicians and nurses are directing at the individuals, families, and communities. These sub-professional workers could be recruited from the local community and trained specifically for public health nursing activities at the level of a practical nurse. Such ancillary health workers could be trained to undertake tuberculin testing, immunizations, health education work, follow-up investigations of patients and families on home TB care, and other routine duties associated with public health work.

(3) One aspect of vocational training for hospitalized tuberculosis patients should include job training for laboratory X-ray, health education, and the ancillary field (public) health work. These trainees would be invaluable in increasing the "human resources" needed to intensify the attack on tuberculosis.

(4) Postgraduate programs in the treatment of tuberculosis should be provided for physicians and other professional health personnel.

V. SOCIO-PSYCHOLOGICAL

THE LACK OF SOCIO-PSYCHOLOGICAL KNOWLEDGE PRESENTS A MAJOR GAP IN THE PRESENT TUBERCULOSIS CONTROL PROBLEM IN KENTUCKY.

GOAL: To provide the solution of obtaining the cooperation of individuals and families in case detection programs and the appropriate treatment when tuberculosis is found.

Therefore, the Conference recommends the following:

(1) All available knowledge of a socio-psychological nature in tuberculosis control should be collected and evaluated for application to the all-out attack on TB.

(2) Research should be encouraged and supported to obtain more information on the behavioral aspects of the patients, families, and communities to TB illness and medical care.

VI. ECONOMIC PROBLEMS

MENTAL ANXIETY CREATED BY THE LACK OF MATERIAL NECESSITIES OF LIFE FOR THE PATIENT'S FAMILY HAS LONG BEEN RECOGNIZED AS A DETRIMENT TO SUCCESSFUL TREATMENT OF THE PATIENT.

GOAL: To provide immediate help to the patient which would include the essentials of living for the patient's family.

Therefore, the Conference recommends the following in cases of proven need:

(1) Broaden economic assistance programs to include those patients without children.

(2) Provide increased financial assistance for TB patients' families.

(3) Work to establish an "Emergency Disaster Fund" to free the "breadwinner" TB patient from financial worry, to give him peace-of-mind from knowing his family is being provided for.

VII. REHABILITATION

REHABILITATION IS RECOGNIZED TO BE AN INTEGRAL PART OF COMPREHENSIVE MEDICAL TREATMENT AND IS ESSENTIAL IN THE TUBERCULOSIS PATIENT'S TOTAL RECOVERY.

GOAL: To provide rehabilitation services from the time of detection to the return of the patient to gainful employment.

Therefore, the Conference recommends the following:

(1) Patients be oriented regarding their disease from the time they are admitted to the hospital.

(2) To make available to TB patients counseling and evaluation services.

(3) The patient be referred for rehabilitation services, if necessary, before he leaves the hospital.

(4) To maintain a close liaison between the TB hospital and the rehabilitation counselor.

(5) To develop more in-hospital training for TB patients by cooperative projects.

(6) Special research and demonstration projects for the rehabilitation of TB patients should be developed in cooperation with the Bureau of Rehabilitation Services and federal grants for this purpose requested.

(7) Facilities be made available for pulmonary function tests to determine rehabilitation potential of TB patients.

(8) There is great need for more rehabilitation services for TB patients in Kentucky. Therefore, immediate attempts should be made to have Congress change the federal distribution formula for federal rehabilitation funds which at present is very inequitable to Kentucky. We also recommend additional appropriations for rehabilitation at the next session of the State Legislature.

VIII. COORDINATION OF ATTACK

As in the conduct of any war, the committee believes in comprehensive strategy which recognizes long-range planning and strengthening of position as well as short-range and immediate action. Extending the analogy of war a step further, the committee became acutely aware of the number of agencies and organizations responsible for activity in tuberculosis control and feels strongly the need of one central authority which will be responsible for coordination of attack.

IX. FINANCING AND UTILIZATION OF ALL RESOURCES

ADEQUATE FINANCING IS VITAL TO AN ALL-OUT ATTACK ON TUBERCULOSIS.

GOAL: To ensure adequate financing of all aspects of the tuberculosis control program in Kentucky.

Therefore, the Conference recommends that money be made available for the following purposes:

(1) To establish and maintain new facilities.

(2) To enlarge and extend present facilities.

(3) To adequately compensate presently employed skilled and professional personnel in order to retain their services.

(4) To recruit and train additional skilled and professional personnel needed.

(5) To establish emergency funds that will be available for the immediate relief of indigent patients and their families.

(6) To initiate and sustain additional medical and social research in those areas of greatest concern.

CONCLUSION

With full awareness of and a deep concern for the seriousness of the tuberculosis problem as it now exists in Kentucky, with the confidence born of the effectiveness of our presently available methods and techniques, and with fervent hope for many new and even more effective methods and techniques, including an effective vaccine, these recommendations are respectfully submitted.

Council Action: The Council accepts the report of the Tuberculosis Committee and would like to recommend that the report be adopted. The Council is aware that the report was referred back to the Council at the 1961 session of the House of Delegates.

Physical Medicine and Rehabilitation Committee, Kenton Leatherman, M.D., Louisville, Chairman

No particular problems have arisen that have required any special meetings to be called during the past year. I talked with various members of the Committee from time to time discussing various problems. However, most members felt that the over-all program of rehabilitation in this state is progressing satisfactorily.

In the Louisville area a financial drive is underway for building a new rehabilitation center which will serve patients throughout this entire area of the state and will also be associated with the University of Louisville physical medicine program. We have heard of no particular plans for a department of this type at the University of Kentucky Medical Center to date.

Council Action: It is recommended by this Council to accept this report as presented.

Dental-Nurse-Pharmacy Committee, Walter R. Johnson, M.D., Paducah, Chairman

There have been no problems or activities necessitating a meeting of this committee for the associational year 1961-1962.

Council Action: It is recommended to accept this report as presented to the Council.

As chairman of the Council on Allied Professions and Related Groups, I would like to express my appreciation to the members of the Council for their assistance in developing our programs. I would also

like to thank the committee members for their time and express to them my sincere thanks for the excellent work they have accomplished during the past year.

Council on Allied Professions and Related Groups
Henry B. Asman, M.D., Louisville
Ralph Denham, M.D., Louisville
Shelby Hicks, M.D., New Castle
W. Vernon Lee, M.D., Covington
J. Farra VanMeter, M.D., Lexington, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reveiwed this report on July 26, 1962. This report was approved in full with the exception of the T. B. Committee report.

Recommendations, Reference Committee No. 4

The report of the Council on Allied Professions and Related Groups contains the following committee reports: Blood Banks Committee, Marion F. Beard, M.D., Louisville, chairman; Infant and Maternal Mortality Committee, William H. Parker, M.D., Owensboro, chairman; Industrial Medicine Committee, Leslie Van Nostrand, M.D., Louisville, chairman; Tuberculosis Committee, Shelby Hicks, M.D. New Castle, chairman; Physical Medicine and Rehabilitation Committee, Kenton D. Leatherman, M.D., Louisville, chairman and the Dental-Nurse-Pharmacy Committee, Walter R. Johnson, M.D., Paducah, chairman.

This report was considered and we want to express appreciation to William H. Parker, M.D., for his splendid cooperation in testifying on the functions of his Infant and Maternal Mortality Committee.

The Committee notes that the report of the Tuberculosis Committee, which was referred back to the Council at the 1961 Session, is this time modified by the Tuberculosis Committee to be acceptable and should be endorsed in principle by the KSMA House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the KSMA Representative on the T. B. Coordinating Council

At the time of the writing of this report, the T. B. Coordinating Council had not held a meeting during this associational year.

Shelby Hicks, M.D.
KSMA Representative

Recommendations, Reference Committee No. 4

This report was approved by our Committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the KSMA Representative on Kentucky Health Council

There has been little action during the past year of the Kentucky Health Council and, unfortunately, I have missed two of the meetings.

There are two things of importance which should be mentioned:

(1) The Kentucky Health Council has been incorporated, therefore, a new organizational set-up is required.

(2) A program publicizing Health Careers has been adopted as the No. 1 project.

The KSMA Auxiliary is supposedly interested in using the Kentucky Health Council for the advancement of the Health Careers publicity.

Carl Cooper, Jr., M.D.
KSMA Representative on the Kentucky Health Council

Recommendations, Reference Committee No. 4

This report was approved by our Committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Resolution E
Highway Safety Committee

"WHEREAS many principles applicable in the reduction of crash injuries in motorcars have been known for over 30 years, have been in use in aviation practice for 15 years, and were explicitly presented in 1948 in the Journal of the American Medical Association by Woodward, and

"WHEREAS these principles are a part of basic engineering knowledge, and have been repeatedly drawn to the attention of the executives in the motorcar industry by medical and other groups, and

"WHEREAS the motorcar industry gave only modest recognition to these principles and practices in its products for the 1956 model year, and despite promises of definite progress in succeeding years, has produced very little improvement in the years since 1956, therefore

"BE IT RESOLVED that the Kentucky State Medical Association urges the automotive industry to incorporate in all motorcars those devices and structures known to be capable of reducing the number of deaths and injuries now occurring on our streets and highways.

"BE IT FURTHER RESOLVED that the Kentucky State Medical Association expresses sincere hope that the motorcar industry can and will incorporate the necessary changes to make individual cars less lethal, avoiding the need for Federal controls such as have been imposed upon other businesses which did not police themselves."

Recommendations, Reference Committee No. 4

Resolution E., relating to the stand of the KSMA to urge automotive safety in manufacturing, is approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Resolution F
School Health Committee

"WHEREAS, the physical and mental well being of the people of Kentucky is of great importance and a natural concern of the medical profession, and

"WHEREAS, the strength of our nation itself directly depends on this same physical and mental health of all Americans, and

"WHEREAS, an expanded well planned and implemented physical education program, concentrated efforts on physical fitness through calisthenics and other planned programs would aid greatly in the promotion of physical fitness, and

"WHEREAS, the Kentucky Department of Education has established a standardized program of physical education as outlined in the booklet, "Youth Physical Fitness," for all schools in Kentucky, and

"WHEREAS, this program could easily be expanded to more completely fulfill the needs of our school children and

"WHEREAS, the KSMA feels that all schools in Kentucky should be encouraged to comply with the Youth Physical Fitness program established by the Kentucky Department of Education,

"NOW THEREFORE, be it resolved that the Kentucky State Medical Association strongly endorses the

principle of increasing the physical educational requirements in our schools by instituting a formal calisthenics planned program, as outlined in the booklet, "Your Physical Fitness," beginning with grade one, and further

"BE IT RESOLVED, that the KSMA commends the Kentucky Department of Education on the progress it has made in the past few years in this important field of physical education and in its emphasis thereon, and that we do offer the support and endorsement of the medical profession of our State to further increase the schools' participation in the standardized physical education program that would thereby greatly aid in the promotion of physical fitness and well being of the children of our Commonwealth."

Recommendations, Reference Committee No. 4

Resolution F, concerning the Physical Education Program in public schools, is approved in principle, and the Committee recommends approval of Resolution F as it was able to acquire testimony concerning the booklet "Youth Physical Fitness."

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution P
Harlan County Medical Society

"WHEREAS, the death toll from highway accidents on Kentucky highways continues to increase, and

"WHEREAS, it has been proven that seat belts materially reduce the morbidity and mortality of passengers involved in automobile accidents, and

"WHEREAS, great credit is due the Legislative Committee and Safety Committee in procuring the passage of SB 30 and HR 43; however, be it

"RESOLVED, that the Harlan County Medical Society unanimously urges that the Legislative Committee take what steps are necessary to obtain the passage of legislation providing for the mandatory installation of seat belts for the front seat of *all* motor vehicles licensed in the State of Kentucky with appropriate penalties for those failing to comply with such legislation."

Recommendations, Reference Committee No. 4

Resolution P, concerning mandatory seat-belts in all automobiles was not approved by our Committee on the premise that it was compulsory and unenforceable.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Mr. Speaker, I move the adoption of this report as a whole. (Motion was seconded and carried.)

Reference Committee No. 4

Richard A. Allnutt, M.D., Covington
James W. Archer, M.D., Paintsville
Charles F. Long, M.D., Elizabethtown
Earl P. Oliver, M.D., Scottsville
Harvey Chenault, M.D., Lexington, Chairman

REFERENCE COMMITTEE NO. 5

B. F. Radmacher, M.D., Chairman
Reports on Medical Service

Report of the Council on Medical Services

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * *

The Council on Medical Services has met twice during the year, January 4, 1962 and July 11, 1962. At its first meeting, the Council discussed the activities of the various committees serving under this Council and took action on the referrals from the 1961 House of Delegates. The Committees serving under the Council are: Insurance Committee, Advisory Commission to Blue Shield, Advisory Committee to Blue Cross, Physicians Placement Committee, Committee on Federal Medical Services, Committee on Aging and Medical Discipline Committee. In addition, the Indigent Medical Care program is under the Council on Medical Services. At this meeting, plans were formulated for activities of these various committees. Those committee chairmen present gave reports on the past and future activities of each respective committee.

The 1960 House of Delegates had recommended that the Kentucky State Medical Association give further attention and study to the need of a benevolent fund for its members and that this question should be referred to the new Council on Medical Services for survey and disposition as it sees fit.

In its 1961 report to the House of Delegates, the Council did not have any recommendations to make concerning this matter inasmuch as it desired further time to contact each member of the Board of Trustees to determine from them if a need for a benevolent fund existed in their respective trustee districts.

The 1961 House of Delegates again referred this matter to the Council on Medical Services. A careful survey has been made and all of the Trustees contacted. As a result of this study, there is no need for a benevolent fund and the majority of the Trustees are against it in principle. Therefore, this Council recommends that no action be taken on it.

Doctor Simpson reported on the Indigent Care program and said that, generally speaking, Kentucky's Indigent Medical Care Program is progressing in a satisfactory manner. Most of the causes of criticism in the early stages of the plan have been corrected. The program is more pleasing to the vendor groups, recipients and the two departments who are charged with its administration.

The extent of utilization continues to present a problem. There is, and should be, a budget in which the program must operate. It has been the policy of the Advisory Council to recommend those services that promote maximum benefits from the taxpayers' money and, at the same time not expend the allocated funds before the end of the budget year.

From January 1961 through December 1961, 279,017 statements were approved for all types of service. During the first three months in 1962, this number was 169,259. January 1 of this year through May 31, 1,047 different physicians representing 114 counties, participated in the program. This is a remarkable increase over the first 12 months of operation. Starting in October up to 120 days' care will be provided in

certain approved nursing homes. Details are presently being worked on to include this group among the other vendors rendering services.

Since the inception of the program, 26,500 of the eligible 55,000 public assistance recipients (PA) have received medical aid. In the medical assistance to the aged (MAA) group, 5,000 of the potentially 87,000 eligibles, have received care. As of June 17, 9,000 MAA individuals have made application for benefits and 8,000 were found to be eligible. It is evident that a large number who are eligible to participate in the program do not feel they need financial help for their medical care. Others do not know about the program or do not realize they may be eligible for its benefits. Still more important is the fact that among those who are eligible, a relatively small number become ill during a specified period of time.

As a closing comment in this report, I want to express my sincere appreciation to Clyde C. Sparks, M.D., and his KSMA Technical Advisory Committee for its guidance and suggestions for improving the program. I would like to thank all physicians in Kentucky for their willingness to participate in a program that is strictly based on need.

The following reports of the committees serving under the Council are herewith submitted:

Insurance Committee, John G. Dickinson, M.D., Glasgow, Chairman

The Insurance Committee met June 7, 1962 with guests. The problem of Release of Information from Medical Records was discussed by Hasty Riddle of the Kentucky Hospital Association, Gaines Davis, KSMA attorney, and others. The Committee commended Mr. Riddle and the KHA for their good work in developing the *Guide for Release of Information From Medical Records.*

The Committee voted to recommend to the Board of Trustees through the Council on Medical Services that the old KSMA insurance claim form be discontinued and that the standardized form developed by the Health Insurance Council be approved and adopted. (Form ID-1, Revised 12-55 H.I.C.).

The charge that an insurance company had been making unreasonable demands for access to hospital records and had refused to pay claims, was discussed with an official of an insurance company and Adam Yancey of the Department of Insurance of Kentucky. The Committee agreed to report to the Council on Medical Services and to the Board of Trustees that an insurance company, in some instances, has made undue demands for access to medical records and this and other of their actions, have been an affront to the medical profession.

A letter from G. L. Simpson, M.D., president of KSMA, concerning the lawsuit and settlement by an insurance company vs. Muhlenberg Community Hospital was discussed. It was taken by common consent to recommend to the Board of Trustees through the Council on Medical Services that the KSMA ask the medical staff of the Muhlenberg Community Hospital to make a record and study of the number of times the insurance company requests photostatic copies of medical records.

Council Action: It is recommended that the report of the Insurance Committee be accepted as presented.

Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., Covington, Chairman

The Medical Advisory Commission to Blue Shield has held one meeting since the last annual report to the KSMA House of Delegates.

On March 8, 1962, the Advisory Commission met at the new KSMA Headquarters building. The chief item considered at this meeting was the proposed new national uniform Blue Shield Senior Citizens Program, which had been developed by the Blue Shield plans, and approved by the AMA Board of Trustees, a few months previously.

After a lengthy discussion regarding the new senior citizens program, the Advisory Commission voted to recommend to the Board of Trustees that the KSMA implement the proposed program as soon as possible, with the understanding that any valid criticisms of the plan which might arise should be passed on to the National Association of Blue Shield Plans.

While it is not usually within the province of this Commission to report on the actions of parent organizations regarding recommendations of the Commission, it would seem timely to point out in this connection, that the Kentucky State Medical Association House of Delegates, in a called meeting, approved adoption of the program, as did the Board of Directors of Kentucky Physicians Mutual, shortly afterwards.

In accepting the National Blue Shield Senior Citizens Plan, the House of Delegates made a provision that the experience of this plan be presented to the KSMA by April 1, 1963, for further consideration and study; and, in addition, the House of Delegates recommended that other insurance carriers should develop and offer appropriate plans for the care of elderly people of low economic status.

It was also recommended by the House of Delegates that further study of the Senior Citizens Programs be instigated toward the early inclusion of all desirable medical services, as well as toward the development of adequate and satisfactory controls.

Another item which was considered at the March 8 meeting of the Advisory Commission to Blue Shield, was a report on the status of the new programs which Kentucky Physicians Mutual developed last year at the recommendation of the Advisory Commission.

Extended benefits have been well received by the public. Up to March 8, 1962, more than 6,000 people in Kentucky were enrolled under this program.

Major Medical became available to Kentucky subscribers on August 1, 1961. By March 1, 1962, there had been enrolled six large groups, involving over 5,000 people.

Approximately 150,000 people in the state have been enrolled under the preferred Blue Shield Contract as of March 1, 1962.

Response to the open enrollment period for senior citizens last fall was less than anticipated. The reason for this was not definitely known.

A report on the status of the *Indiana Plan,* which was approved by the KSMA House of Delegates at the September 1961 meeting, indicated that the plan had not yet been put into operation in Kentucky, but that two of the larger county medical societies have been considering the advisability of adopting a "Pay All" plan for use in negotiating with certain large industrial groups.

Considerable discussion was devoted, both in this and in previous meetings of the Advisory Commission, to the need for better education of the public and of the medical profession in the objectives and problems of our Blue Shield Plan. This will doubtless be a subject of continuing study in future meetings of the Commission. At this critical period in the history of our profession the survival of our system of medical practice depends to a large extent on the success of our voluntary prepayment plans. It is to the interest of our profession to work toward the continuing improvement of prepayment coverage for health care.

Council Action: It is recommended by the Council that the report of the Advisory Commission to Blue Shield be accepted as presented.

Advisory Committee to Blue Cross, Sam A. Overstreet, M.D., Louisville, Chairman

The Advisory Committee to Blue Cross meets once a year at the Annual Meeting to outline the general

policies. Letters of information are sent out during the year and the Committee tries to help in keeping the claims in order. The Committee keeps advised of trouble spots throughout the state.

The Committee has been of help in the area of setting up review committees. Many hospitals have set up review committees and where they are established, they are of help in cases needing appeal. This Committee tries to endorse the report of the review committees, but in about three cases it has been necessary to request an adjustment of a report.

The establishment of review committees in hospitals is widely recommended in other areas and will eventually be accepted here.

Council Action: It is recommended that this report be accepted.

Physicians Placement Committee, Delmas M. Clardy, M.D., Hopkinsville, Chairman

The routine functions of this service are well established since its inception eight years ago. There have never been any real changes in the service, only improvements and additions.

Mr. Grogan and his staff do all the work, which consists of keeping an up-to-date list of physicians wanting placement and lists of communities wanting and needing physicians. This list has been expanded to include specialists and we are particularly interested in assisting the placement of radiologists, pathologists and anesthesiologists. A complete list, location and activities are kept on senior medical students, interns and residents until they are located in practice. We also try to include Kentucky students, interns and residents in out-of-state schools and hospitals.

Mr. Grogan has in his office a map of Kentucky set with colored pins, which gives an immediate current analysis of the situation in each locality.

This service cooperates with the AMA placement service, the Sears-Roebuck Foundation and the Board of the Rural Scholarship Fund, all of which are very active.

It was not necessary for this Committee to have a regular meeting this year, but three of its members did meet with the Board of Trustees of the Rural Scholarship Fund.

Council Action: The Council recommends that the report of this committee be accepted.

Committee on Federal Medical Services, O. Leon Higdon, M.D., Paducah, Chairman

This shall constitute a report of the Committee on Federal Medical Services relating to the Medicare program. There has been no called meeting of this Committee during the past year. Much has been done by communication with the KSMA Headquarters Office in the matter of endorsing contract changes.

Also, in early June a petition was filed with the Medicare director for renewal of contract for the coming year. As you know, this must be made six months in advance of contract signatures. Prior to that time, letters were sent to all county medical societies and notices issued through the KSMA Journal soliciting suggestions or criticisms related to the program. Apparently our membership is satisfied with the program as we have received no suggestions or criticisms.

I recommend no change in our present contract.

Council Action: It is recommended that the report of the Committee on Federal Medical Services be accepted.

Medicare Review Committee, McHenry Brewer, M.D., Louisville, Chairman

During the past year the Committee has reviewed and acted upon approximately 200 cases which represents a very small percentage of the total number of Medicare cases. (Approximately 5%.)

The Committee met on one occasion during the year with Don Cherrie, Blue Cross Hospital Plan, Mrs. Ruby Laws, Medicare Department, Dave Greenwell Blue Cross-Blue Shield.

The background of Medicare was reviewed and the procedures followed in evaluating controversial Medicare claims were discussed in detail.

The Committee felt that it would be wise to have additional members on the Committee representing orthopedic surgery, internal medicine and neurosurgery. It was recommended that the Board of Trustees choose one name from each specialty submitted to be included as members on the Medicare Review Committee.

Orthopedic Surgery:	Charles R. Hoffman, M.D. William C. Mitchell, M.D.
Internal Medicine:	Walter S. Coe, M.D. Robert S. Tillett, M.D.
Neuro-Surgery:	Thomas M. Marshall, M.D. Ludwig H. Segerberg, M.D.

It was agreed that the Medicare claims which needed reviewing by the Committee would be distributed among the Committee members according to their specialty in order that the claims can be considered by a physician in the proper specialty.

Council Action: It is recommended that this report be accepted.

Aging Committee, Earl P. Oliver, M.D., Scottsville, Chairman

The KSMA Committee on Aging met once during the 1961 associational year and had as guests, the Rev. H. Dix Archer, Chairman of the Citizens Commission on Aging, the president-elect of the American Geriatrics Society, A. Clayton McCarty, M.D., Louisville and Avil McKinney, A Blue Shield-Blue Cross representative. The Committee again met April 17, 1962 and made the following recommendations:

With medical care for the aged still commanding a large share of the spotlight on the national legislative scene, it is the opinion of this Committee that in keeping with American traditions, it is first the primary responsibility of the individual in providing for his medical care as well as other personal care. When the individual is unable to provide this care for himself, the responsibility should rightfully pass to his family, then to the local community, county and state, and all in that order. Then, and only then, should the federal government assume a role, and then only in cooperation with the other governmental bodies heretofore cited.

In this connection our Committee also endorses the Kerr-Mills program in Kentucky and it is our opinion that all physicians in Kentucky should solidly unite behind this program and actively participate in order to make this program do the most good for those who are needy and eligible under the program. We see no merit in the argument of those who decry about the "Means Test" in this legislation. Without some sort of restriction or "means test" the program could become unmanageable. All of us in our everyday living are confronted with different types of means tests and this test is vital in determining who needs help, and it came into being as a method of saving the people's taxes for use where they were most needed.

Additionally, our Committee recommends to the Council on Medical Services that:

1. We commend the Kentucky State Legislature and Governor Combs for establishing the Citizens Commission on Aging as a permanent body under statutory regulations.

2. We again reaffirm our position that the KSMA work with the Kentucky Association of Nursing Homes in ways to improve quantity and quality of these facilities. This would make available less expensive hospital type care for the less seriously ill

aged citizens and leave more beds available for the acutely ill.

3. The KSMA and county medical societies encourage the establishment of chronic and convalescent care units in connection with new and existing hospitals.

4. We, as physicians, speak up on the issue of freedom of medical practice and freedom in all walks of life in preference to socialistic programs which would be more expensive and less effective and that we, as physicians, ask our patients to express their views to their congressman and senators.

5. The KSMA and its component societies devote more study to nurse recruitment in an effort to alleviate the shortage of registered nurses in Kentucky and that we also devote study to establishment of additional schools for licensed practical nurses and recruitment for this program.

6. County medical societies take the leadership in well adult conferences on aging and institute educational programs for elderly persons on the importance of:

a. Periodic health examinations and preventive medicine
b. Accident prevention and education
c. Proper nutrition in maintenance of good health

7. That we again reaffirm our opposition to compulsory retirement at age 65, but rather, it be based on ability to perform, etc. We should encourage that younger segment of our population to begin in their youth to prepare themselves for old age and retirement.

8. The KSMA Advisory Commission to Blue Shield and the Blue Shield-Blue Cross staff be commended for its efforts and study in again offering to those over 65 an opportunity to purchase coverage on hospitalization and medical care. We would recommend that any open period of enrollment be fully publicized so that all in Kentucky may know of this offering and that a News Release be prepared by the KSMA on this enrollment period noting that over 80,000 people in Kentucky over age 65 are now covered. We would also encourage the commercials to provide low cost insurance for the aged. We feel this to be another positive step in the health care for the aged.

9. The KSMA explore the possibility of preparing a pamphlet which could serve as a buyers guide to those over 65, as well as those under 65, purchasing voluntary health insurance.

Council Action: It is recommended to accept the report of the Aging Committee.

Medical Discipline Committee, R. E. Pennington, M.D., London, Chairman

During the last meeting of the Kentucky State Medical Association, resolutions were introduced by two county medical societies urging that some steps be taken towards increasing the efficiency of the Medical Discipline Committee. One of these resolutions was presented by the Laurel County Medical Society of which the chairman is a member.

Early this year, I was appointed chairman of the Medical Discipline Committee by the President and I have consulted with the legal counsel of the Kentucky State Medical Association and, in addition, have had correspondence with the Department of Medical Ethics of the AMA.

The Director of the Department of Medical Ethics of the AMA, Edwin J. Holman, has informed me that the Council on State Governments is at the present time working with the National Conference of Commissioners on uniform state laws to draft a model medical practice set. Representatives of the AMA, the Federation of State Medical Boards and others, are acting as an advisory commission to the Council.

Gaines Davis, the legal counsel of KSMA, has advised that the present laws in Kentucky are as ample as those of the State of Washington which was suggested as a model in the resolution presented by our Society.

Since the Kentucky State Legislature does not meet for over another year, and in view of the fact that proceedings are underway for uniform state laws and the drafting of a model medical practice act, it is my impression that action of the Disciplinary Committee toward these resolutions should be postponed until a report by the Council of State Government is made.

Council Action: It is recommended that this report be accepted.

The chairman of the Council on Medical Services would like to commend the committees, their chairmen, and the committe members, along with those who have served on the Council on Medical Services. The chairman feels that there are many items contained in this report which deserve the careful and undivided attention of the KSMA and its members in the fulfillment and implementation of some of these programs.

Council on Medical Services
John Dickinson, M.D., Glasgow
Earl P. Oliver, M.D., Scottsville
Sam A. Overstreet, M.D., Louisville
W. Vinson Pierce, M.D., Covington
Claude Waldrop, M.D., Williamstown, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on July 26, 1962. The Board took a blanket action on this report that it be approved in full.

Recommendations, Reference Committee No. 5

1. This report was carefully studied by the committee and its first phase had to do with the establishment of a benevolent fund for the members of KSMA. It was the feeling of the Council that there was no need for such a fund and the council advised that no action be taken on it. The reference committee concurs in this.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

2. Indigent Care Program—This deals with the Indigent Care program. The committee carefully discussed and considered this report, particularly since part of this report also advised us concerning the Resolutions N and O and after due consideration it was felt that this report was excellent. We also concur and feel that the KSMA Technical Advisory Committee should be complimented for their guidance and suggestions for improving the program.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

3. Insurance Committee—The Insurance Committee deals particularly with the adoption of a standardized insurance form. It was the opinion of the committee that this represents a good thought and should be adopted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

4. Advisory Commission to Blue Shield—This Commission after lengthy study recommended to the Board of Trustees that the KSMA implement the Senior Citizens program with the stipulation that further study of the program be instigated toward the early inclusion of all desirable medical services as well as toward the development of adequate and satisfactory controls. The committee agrees with these recommendations.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

5. Advisory Committee to Blue Cross—This report is short and advises that admission review committees be established in hospitals and we endorse this part of the report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

6. Physicians Placement Committee—The report of the Physicians Placement Committee was studied and agreed upon in its entirety.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

7. Committee on Federal Medical Services—The Committee on Federal Medical Services did not meet, but recommends no change in present contract.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

8. Medicare Review Committee—It is the advice of the Medicare Review Committee that additional members be included and a different form of handling claims be set up. This committee concurs in their findings.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

9. Aging Committee—This committee has obviously put a lot of effort into their work and the Reference Committee compliments them on their report.

There are two paragraphs in their report which we feel should be commented upon. The first deals with a program as follows:

> "With medical care for the aged still commanding a large share of the spotlight on the national legislative scene, it is the opinion of this committee that in keeping with American traditions, it is first the primary responsibility of the individual in providing for his medical care as well as other personal care. When the individual is unable to provide this care for himself, the responsibility should rightfully pass to his family, then to the local community, county and state, and all in that order. Then, and only then, should the federal government assume a role, and then only in cooperation with the other governmental bodies heretofore cited."

It is the feeling of this committee that this paragraph represents traditional American thinking and should be kept in our minds.

The second paragraph deals with the fact that the committee endorses the Kerr-Mills program in Kentucky and advises that all physicians in Kentucky should solidly unite behind this program and actively participate in the program. We feel that this, too, represents advance thinking by the committee. The committee feels that this is an excellent report and concurs in its recommendations.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

10. Medical Discipline Committee—The Medical Discipline Committee report was carefully studied and approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried).

Report of the Board of Directors of Kentucky Physicians Mutual, Inc.

The Board of Directors of Kentucky Physicians Mutual, Inc., respectfully presents its annual report to the Kentucky State Medical Association. It reflects the 13th year of operation and service to the people of Kentucky.

As of July 31, 1962, 764,857 people were members of the Plan, reflecting an increase of 46,575 over the membership one year ago. During the 12-month period ending June 30, 1962, $7,187,516 was paid to physicians. This is an increase of $621,598 over the previous 12-month period. It is estimated that for the calendar year 1962 payments to physicians will exceed $7,600,000.

The cost of operation for the 12 months ending June 30, 1962, was 9.9% of income. It is interesting to note that of the 74 Blue Shield Plans in this country only four operated at less administrative cost per member than the Kentucky Plan.

In October of 1961 an open enrollment period was held, and all persons in Kentucky were eligible to apply for Blue Cross and Blue Shield. An extensive advertising campaign was carried out, which resulted in 1,034 persons over 65 years of age enrolling and 1,021 persons under 65, making a total of 2,055.

The year has been one of great progress in expanding benefits to more realistically meet the needs of the people. The national Blue Shield organization completed formulation of a Physicians' Service Index as a guide to fee schedules. Extensive study was made of this, and the Board adopted it as an ideal method of making more equitable the relation between indemnities on the various procedures. The assistance of the various specialty groups in working out these schedules is greatly appreciated and is hereby acknowledged.

It is planned to begin putting the new schedules into effect about January 1. As these schedules will result in a raise in payments in many procedures for subscribers, an upward adjustment in their dues will be made.

In addition to the adoption of the Physicians' Service Index, certain other higher schedules have been instituted, and subscribers have been urged to upgrade their coverage wherever possible.

Approximately 21,233 persons are now enrolled in our Extended Benefits program, and 7,089 persons in the Major Medical coverage. The number covered under these two plans is growing daily.

In cooperation with all the Blue Shield Plans throughout the country and also Blue Cross, an enrollment period for the aged will be held nationwide in October of this year. You will be advised further of the complete plans, and an extensive advertising campaign will be carried on at that time.

In closing I want to express my deep appreciation to members of the profession who have helped in revising our benefits this year, also, to the members of the Board, fellow officers, and the staff for their assistance in making this one of the most successful years in our history.

John Dickinson, M.D.
President

Recommendations, Reference Committee No. 5

The report of the Board of Directors of the Kentucky Physicians Mutual, Inc., was carefully studied and discussed and it was noted that there will be an enrollment period for the aged held on a nationwide basis in October of this year. It is our feeling that the Board of Directors is doing an excellent job and we approve of their report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Report of the Rural Kentucky Medical Scholarship Fund

Since the last report to the House of Delegates the Rural Kentucky Medical Scholarship Fund has continued to make excellent progress. More medical students have been approved for loans, more recipients of loans have located in rural areas and more money

has been forthcoming from the Commonwealth supplementing the Fund.

For the fall term beginning last September 22 students received their first loans. Seventy-nine students were in medical school this past year who have received money from the Scholarship Fund. Each first loan applicant approved last fall received $1.000 for the school year and will continue to receive this amount for each year in medical school. The same applies to those coming in this September. Those who received loans prior to this date will continue to receive $900 per year just as they have in previous years. There was not enough available money in the revolving fund to loan $1,000 to each recipient in the second, third and fourth loan group.

The number of requests for loans has increased considerably since the opening of the University of Kentucky Medical School. Beginning this fall recipients of Rural Scholarship loans will be in medical schools as follows: University of Louisville—(31); University of Kentucky—(20); George Washington University—(1); University of Tennessee—(3); University of Cincinnati—(1); St. Louis University—(1); Tulane University—(1) and Vanderbilt University—(1).

Because of the large number of Kentucky residents requesting loans the trustees of the Fund no longer consider applicants for loans received from non-residents.

During the past year 11 recipients have located in areas approved by the Board. This makes a total of 80 now in rural practice. Several others are practicing in larger towns in Kentucky who have completed their moral obligation. Those receiving loans cannot locate in the counties of Campbell, Daviess, Fayette, Jefferson, Kenton and McCracken but can in other counties with the exception of the following towns. They are: Ashland, Bowling Green, Frankfort, Henderson, Hopkinsville, Madisonville, Middlesboro and Richmond. Recipients that locate in any of the 10 most critical counties have one loan canceled for each 12 months of practice in the critical area. To further encourage physicians to locate in this needy area, the University of Louisville Medical School refunds all tuition to its graduates who will practice at least three years in one of the critical counties.

It is a pleasure to work with the enthusiastic doctors and lay people composing the Scholarship Board of Trustees. The attendance at Board meetings is near perfect and each member takes an active interest in the program. The KSMA Headquarters Office staff is doing a good job keeping the essential records and working with students from the time they make application for loans until the recipient has become established in practice.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Glasgow
Chairman, Board of Trustees

Recommendations, Reference Committee No. 5

It is obvious that the Rural Kentucky Medical Scholarship Fund is growing; is providing Kentucky with more doctors in the rural areas and is performing a good service for our society.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Report of the Advisory Committee to Selective Service

During the past year there have been relatively few calls regarding a possible change in status for Physicians classified under the Selective Service Act. None of these have resulted in any controversy.

Very satisfactory working relations are in effect between your committee and the governmental authorities.

Advisory Committee to Selective Service
O. B. Coomer, D.D.S., Louisville
Sam A. Overstreet, M.D., Louisville
L. O. Toomey, MD., Bowling Green
Glenn U. Dorroh, M.D., Lexington
Sydney G. Dyer, M.D., LaCenter
Charles Billington, M.D., Paducah
F. E. Hull, D.V.M., Lexington
Lula B. McClain, R.N., Louisville
Marcus Randall, D.D.S., Louisville
Russell E. Teague, M.D., Frankfort
Frank Jordan, D.D.S. Louisville
J. Duffy Hancock, M.D., Louisville, Co-Chairman
A. Clayton McCarty, M.D., Louisville, Co-Chairman

Recommendations, Reference Committee No. 5

There was no specific action taken by the Advisory Committee to Selective Service during the past year and the report was accepted as such.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried).

KSMA Technical Advisory Committee to the Indigent Medical Care Program

The KSMA Technical Advisory Committee to the Governor's Advisory Council on Indigent Care has had one formal meeting since the last session of the House of Delegates. Informal discussions have been held on several occasions. In addition, your chairman has met several times with the Governor's Advisory Council and each member of your Technical Advisory Committee has been kept informed on the operation of the Program and the proceedings of the Governor's Advisory Council.

Generally speaking, the Program is making satisfactory progress. It is observed that there has been an increase in participation on the part of the members of the medical profession. The Committee approved expansion of the Program to include nursing homes as participating members of the vendor groups. It is anticipated that this Program will become active January 1, 1963.

The Committee received the Campbell-Kenton and Daviess County medical societies resolutions which were adopted at the 1961 House of Delegates. It has attempted to re-evaluate the Program and has worked to eliminate many of the inequities mentioned in the resolutions.

The KSMA Board of Trustees supported your Committee's position and recommendations that physicians who have only one office and that located in a hospital should be paid for office calls.

Relationships with the Division of Medical Care of the State Department of Health have been very gratifying and satisfactory.

KSMA Technical Advisory Committee to the Indigent Medical Care Program
Mitchel B. Denham, M.D., Maysville
Donald Graves, M.D., Frenchburg
G. David McClure, M.D., Louisville
Claude C. Waldrop, M.D., Williamstown
Clyde C. Sparks, M.D., Ashland, Chairman

Recommendations, Reference Committee No. 5

The report of the KSMA Advisory Committee to Indigent Medical Care program was carefully studied and it is noted that it has already been complimented

upon its actions. We feel that this committee should be constantly aware of the possibility of improving this program and advise that they study all proposals submitted to them with the expectation of further implementing the Kerr-Mills program in a manner that will be satisfactory to all.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Resolution D

Kentucky Society of Pathologists

"WHEREAS, the practice of pathology, both clinical and anatomical, has been declared repeatedly to be the practice of medicine by the AMA, by the Kentucky State Medical Association, by other state and county medical societies, by the College of American Pathologists, and other special professional societies, by the courts of record having certain legal jurisdictions, and by opinions of record of attorneys general of certain states; and

"WHEREAS, there are medical laboratory technicians and other non-professional persons operating independent medical laboratories on a commercial basis without proper medical licensure, without adequate education or training, and without proper professional supervision; and

"WHEREAS, persons operating such commercial laboratories are not constrained by law or by their education and training to adhere to professional ethical principles guarding the public interest; and

"WHEREAS, such commercial laboratories frequently charge fees to physicians under conditions fostering the division of fees between the laboratory and the referring physician; and

"WHEREAS it is desirable to encourage scientists of professional status, such as chemists and bacteriologists with doctoral degrees, to work cooperatively with physicians for the welfare of patients and in the interest of public health; and

"WHEREAS, the independent practice of laboratory medicine, generally known as pathology, by persons without medical licensure degrades the practice of medicine and of pathology in particular, is against the public interest and seriously lowers the medical and scientific standards of medical practice; and

"WHEREAS, the medical profession generally has always placed the common good above self-interest and has adhered to ethical and moral principles, now therefore be it

"*Resolved,* that the Kentucky Society of Pathologists hereby declares that the proper conduct of laboratory analyses is a medical professional responsibility and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians."

"Adopted by the Kentucky Society of Pathologists at regular session, June 9, 1962."

Recommendations, Reference Committee No. 5

It is the opinion of this reference committee that Resolution D should be adopted and we suggest that the Kentucky Society of Pathologists acquaint the members of the KSMA through the medium of our State Medical Journal with the names and organizations of qualified laboratories and the procedures which they are able to perform.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Resolution M

James B. Douglas, M.D., delegate from Jefferson County, Alternate Councilor of American College of Radiology and Councilor of Radiological Society of North America.

"WHEREAS, Physicians and all medical organizations oppose and resent the hiring of physicians by hospitals with a resale of the services of these doctors for medical fees, whether such fees are paid directly by the patients, or through the medium of prepayment or insurance; and

"WHEREAS, The past actions of the House of Delegates of the American Medical Association and numerous courts of law have held many times that the practice of radiology, anesthesiology, pathology and psychiatry constitute the practice of medicine; and

"WHEREAS, The National Blue Cross Coverage plan for the Aged which is being circulated for approval by state and local organizations define as 'covered hospital services,' for in-patients, laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, basal metabolism tests, radiation therapy, physical therapy, anesthetics and oxygen and administration thereof, administration of blood and blood plasma, intravenous injections and solutions, when furnished and billed for as a regular hospital service; and

"WHEREAS, this plan also includes as 'hospital out-patient care,' emergency treatment for accidental injury within 72 hours after an accident, x-ray and radiation therapy, and physical therapy; and

"WHEREAS, The American Medical Association has re-affirmed many times through its Bureau of Medical Economics, its Judicial Council, and the House of Delegates the principle that hospital service plans should exclude all medical services; and

"WHEREAS, from the viewpoint of inclusion of medical services the proposed Blue Cross Contract and the legislation being designed to support it, is just as repugnant as the King-Anderson Bill; and

"WHEREAS, the special called meeting of the House of Delegates of KSMA and the Advisory Commission to Blue Shield, approved the National Blue Shield Senior Citizens Program only after prolonged debate and with the understanding that any valid criticisms and recommendations should be passed on to the National Association of Blue Shield Plans; now, therefore be it

"*Resolved,* that the House of Delegates for the KSMA go on record as urging that every effort be made to exclude coverage of medical services from the Blue Cross contracts as they are approved by the member plans, and be it further

"*Resolved,* that medical coverage be provided by Blue Shield contracts and commercially underwritten contracts, and if coverage is required by circumstances, that it be provided under Blue Shield riders to the Blue Cross Contract as has been done on many occasions, such as in Michigan, Kansas, Missouri, Nebraska, etc."

Recommendations, Reference Committee No. 5

Resolution M was carefully considered and evaluated. It seems to us that it has some excellent points, but we did not feel that we could adopt it in its present form. Therefore, it is our recommendation that this resolution should be referred to the Board of Trustees for further study.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Resolution N

Pike County Medical Society

"WHEREAS, the principle of free choice of physician and fee for service is the standard for medical practice in Kentucky, designed to preserve a doctor-patient relationship of the highest quality, and make each physician fully responsible for his acts and,

"WHEREAS, the medical profession has always cared for patients regardless of race, creed, or economic status, and shall continue to do so, and,

"WHEREAS, the physician alone is legally and morally responsible for the quality of medical service and,

"WHEREAS, a third party can do no more than to qualify a person to participate in whatever funds the third party has for medical services, and,

"WHEREAS, the medical profession pledges itself to the preservation of principles which have resulted in medical service of the highest quality, and

"WHEREAS, medical care program established by the government or its agencies should only provide for beneficiary participation in the agency's appropriated funds.

"*Therefore be it resolved* that the KSMA *Recognize* that physicians are not participants in any program of the government or its agencies, except in an advisory capacity, and recommend to the Congress the following administrative procedures, which will clearly delineate the responsibilities of each party in participation:

"(1) The patient shall seek medical service from the physician of his choice and complete the financial arrangements to pay for services rendered. The patient shall receive a receipt or statement of the amount due, which he may use as a basis for participation in the agency funds. The agency may use this data to clarify the extent of its participation.

"(2) The agency may, in the case of those presenting a statement, require that a receipt from the billing physician for the amount disbursed be presented before the patient is eligible for a disbursement for a second service.

"*Be it further resolved* that no member of the Kentucky State Medical Society should willingly cooperate with any future government aid program, except on the above basis.

"We urge the adoption of this resolution."

William C. Hambley, M.D., President
Pike County Medical Society"

Recommendations, Reference Committee No. 5

Resolution N has points of merit that in our opinion need further study and clarification regarding its possible use in the future. However, in its present form it is ambiguous and does not clearly define the issues involved. Therefore, it is the opinion of this committee that the resolution should be returned to the Board of Trustees for its further evaluation.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Resolution O

Warren County Medical Society

"WHEREAS, The House of Delegates of the Kentucky State Medical Association has endorsed the Kerr-Mills approach as the best approach to medical aid for the medically indigent of the Commonwealth of Kentucky, and

"WHEREAS, The practicing physicians, the Governor's Advisory Committee, the Department of Economic Security, and the present administration of the Commonwealth are mutually anxious that the maximum number of eligible citizens receive this aid since it was intended for their benefit, and

"WHEREAS, Full participation by the practicing physicians of the Commonwealth in this program will help demonstrate the profession's ability to maintain its high standards of universal medical care without government control and administration of the field of medicine, and

"WHEREAS, It has long been the practice of the medical profession to attend the sick to the best of its ability regardless of the patient's ability to pay and this has been mutually satisfactory to all concerned, and

"WHEREAS, A sizable number of physicians of this Commonwealth have found that they cannot accept fees paid by a third party for the care of the indigent simply because they are poor, and

"WHEREAS, The resources of the Kerr-Mills program are not being fully utilized by the present method of administration in the Commonwealth of Kentucky: therefore be it

"*Resolved:* That the House of Delegates of the Kentucky State Medical Association instruct the representative of the Kentucky State Medical Association on the Governor's Advisory Committee to recommend to the Committee that it advise the following adjustments in the Kerr-Mills program as administered in the Commonwealth of Kentucky:

"1. That there be no drug list, special prescription blanks, or similar restrictions of treatment by a physician licensed by the Commonwealth and that ordinary usual prescriptions for recipients of this aid be filled by qualified pharmacists at a fee agreeable to them and the Administration upon certification of their eligibility for this aid by the proper agency.

"2. That consent forms be executed by the patient before the diagnosis of his illness and the treatment thereof are divulged to third parties.

"3. That physicians' fees be eliminated from the program.

"4. That funds so conserved be utilized in other areas of this program.

"5. That a committee continue to study the employment of Blue Cross-Blue Shield as fiscal agents for this program and report its findings to the House of Delegates."

Recommendations, Reference Committee No. 5

The committee seriously considered this Resolution O and found it to contain some very good thoughts and ideas that could be used favorably by the KSMA Technical Advisory Committee to the Indigent Medical Care Program. In view of the fact that the Kerr-Mills program is still in its infancy and now beginning to function in a most satisfactory manner, it is our opinion that Resolution O could best be used by referring it to the above committee for their study and use.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of this report as a whole. (Motion seconded and carried.)

Reference Committee No. 5
B. F. Radmacher, M.D., Louisville
David M. Greeley, M.D., Harlan
R. Ward Bushart, M.D., Fulton
E. C. Strode, M.D., Lexington
Salem M. George, M.D., Lebanon
Harold Keen, M.D., Bowling Green

REFERENCE COMMITTEE NO. 6

C. J. Shipp, M.D., Chairman
Reports on Constitution and Bylaws; Special Committees

Report of KSMA Advisory Committee to the Editor

This committee has had the privilege of association with one of the best-organized activities of the Association.

A special meeting of the Committee was called early in the year, attended by the more centrally-located members of the Committee. The long deadline of a symposium issue required prompt decision early in the Committee's year. Beverly Towery, M.D., graciously assumed the responsibility for editing the symposium issue, which was scheduled to be devoted to "Acute Infectious Diseases."

All members of the Committee, and the entire editorial staff, were present at a formal committee meeting February 15, privileged to be the first committee meeting in the new headquarters building.

All matters of policy and the various problems of the editorial staff were thoroughly reviewed.

In addition to the designation of new appointees to the Board of Consultants to replace the eight members whose terms expired, the other actions of more general interest which were taken included:

a. The selection of a new cover format for The Journal.
b. Consideration of the issue of The Journal which constituted the dedication issue for the new headquarters building.
c. Recommendations for continuation of the editorial policy of freely exchanging subscriptions to The Journal, for the widest possible exposure in libraries in medical schools. While no cash benefits can be assigned to prestige, The Journal is an ambassador spreading the tidings of the attainments and activities of our members to the medical world.
d. Commendation of the editorial policy of giving preference, in the scientific pages, to contributions from the members. The Committee was disturbed at the relatively small number of scientific manuscripts received from our members and has suggested a number of thoughts for attracting more scientific contributions to The Journal.

On motion of the editor, the Committee was happy to recommend an increase of 10% in compensation from Journal funds for Joseph Sanford, the managing editor.

The Committee, by various comparisons, feels that the Kentucky Journal has in recent years made marked improvements and by any standard stands well up in the forefront among the more distinguished state journals. The Committee cannot commend too highly the desire for excellence which is a characteristic of every member of the editorial staff.

I am proud to report that every member of the Committee was diligent in attendance at all meetings, and each made thoughtful contributions to the deliberations. I thank them for their sincere interest.

KSMA Advisory Committee to the Editor
Henry B. Asman, M.D., Louisville
Blaine Lewis, M.D., Louisville
Francis M. Massie, M.D., Lexington
Willett H. Rush, M.D., Frankfort
G. F. Brockman, M.D., Chairman, Greenville

Recommendations, KSMA Board of Trustees

The KSMA Board of Trustees reviewed this report at the July 26 meeting. Board action: The report was accepted as presented.

Recommendations, Reference Committee No. 6

We accept and recommend this report as a whole. We commend the work of the editorial staff and the Advisory Committee and concur with their policy of encouragement of more contributions of scientific manuscripts from our members.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Report of the Professional Relations Committee

No matters were referred to our committee this year for action.

A resumé of activities within the districts is on file in the headquarters office and may be reviewed by any member upon request.

Professional Relations Committee
E. B. Mersch, M.D., Covington
Robert W. Robertson, M.D., Paducah
Irvin Abell, M.D., Louisville
Richard R. Slucher, M.D., Buechel, Chairman

Recommendations, KSMA Board of Trustees

The Board reviewed this report at its July 26 meeting. Board action: The report was approved in full.

Recommendations, Reference Committee No. 6

It was noted that no matters were referred to this committee for action. A resumé of its activities within the districts is on file in the Headquarters Office and is available to any member upon request.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Report of the KSMA Committee on Third Party Medicine

The Committee on Third Party Medicine did not feel there was a necessity for having a meeting, therefore, we do not have a report to present.

KSMA Committee on Third Party Medicine
Winfrey P. Blackburn, M.D., Frankfort
Ballard Cassady, M.D., Pikeville
Daryl Harvey, M.D., Glasgow
Thomas McElhinney, M.D., Covington
John S. Harter, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

The report of this committee was accepted as presented.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Report of the Committee to Study Constitution and Bylaws

Your committe met May 9 in the headquarters office building and gave long and careful study to the following recommendations to the House of Delegates. Action of the Board of Trustees on these recommendations will be found at the conclusion of this report.

The committee studied at some length the procedure by which committees and councils report to the House of Delegates through the Board of Trustees. It reviewed the operation of the new committee and council structure which was adopted at the 1960 session of the House of Delegates, noted the over-all improvement in the Association's activities and made the following recommendation in order to facilitate procedures:

". . . . that the Association's councils be instructed to submit to the House of Delegates, via the Board of Trustees, the complete reports of all committees. Attached to these reports would be comments from the council, or a short summary of matters it feels merit the particular attention of the Board. The summary should represent the formal report of each council and these reports and summaries should be mailed to the Board of Trustees 10 days in advance of the meeting at which the Board considers committee and council activity."

Protocol for Committees to Follow

Your committee studied a situation which infrequently arises but for which it was felt there should be some positive ruling for handling in the Bylaws. These situations involve committees of a council bypassing the council to other groups. In order to correct this, the committee voted to recommend the following addition to Chapter VII, Section 4:

"All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recom-

mendations will be considered by the Board of Trustees unless and until reveiwed by the proper council."

Medicolegal Matter

The committee learned that during the year the KSMA medicolegal administrator, John D. Gordinier, M.D., Louisville, had appeared before the KSMA Board of Trustees and recommended that we discontinue keeping a firm of attorneys on retainer to provide assistance in professional liability matters and that his office be abandoned. He said there were a number of reasons for making this recommendation.

The Board of Trustees voted to discontinue the retaining of the special firm of attorneys but asked the Bylaws Committee to study the matter of discontinuing the medicolegal administrator's office and report to the House of Delegates.

Chapter VI, Section 9 of the Bylaws, which covers the present operation of this office, follows:

"A medicolegal administrator shall be appointed by the Board to serve for a term of three years. The Executive Committee of the Board shall act in an advisory capacity to the administrator. The Association, through the administrator shall, upon the request of any member in good standing who is a defendant in a professional liability suit, provide such member with the consultative service of competent legal counsel selected by the administrator acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court."

Following thorough discussion, the Bylaws Committee recommends the following revision:

"The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative services of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court."

It was suggested that the members of KSMA be kept informed relative to the developments in the medicolegal field.

Quorum for KSMA House of Delegates

The committee studied the recommendation that a specific number be set for the quorum of the House of Delegates in the Bylaws. The present Bylaws covering this matter in Chapter III, Section 6 follow:

"A majority of the registered delegates shall constitute a quorum and all the meetings of the House shall be open to members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions."

Following lengthy consideration the committee voted to recommend that Chapter III, Section 6 of the Bylaws be changed to read as follows:

"Seventy-five voting delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions."

Correction of Wording, Chapter IV, Section 2

Inasmuch as the 1961 House of Delegates voted to change the name of the County Society Officers Conference to the Interim Meeting, the committee recommends that the term "Interim Meeting" be substituted for County Society Officers Conference whenever it appears in Chapter IV, Section 2.

Grievance Committee Procedures

It was felt by the committee that there was no adequate provision for appeals to the Board of Trustees from members disciplined at the county society level. Following careful consideration, the committee recommends that Chapter XI, Section 10 of the Bylaws be amended to add the following:

"Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

"Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Board of Trustees, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Board of Trustees to those portions of the transcript upon which he relies."

"Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Board of Trustees.

"No member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees, may resign, and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees."

Recommendation on Dues

At the May 9, 1962, meeting of the Executive Committee, the question of consideration of an increase of dues for 1963 on a temporary basis was referred to the Bylaws Committee for consideration. It was explained that if the necessary money could be raised to clear the debt on the new building, a very considerable amount of interest could be saved—thus leaving unimpaired the other operations of the Association.

The Association's attorney was authorized to look into this matter and make recommendations. Following is the report from our attorney:

Assessment Resolution

"In my opinion, no change in the Bylaws is required in order to put into effect the assessment which was voted by the Board of Trustees at its last meeting. I would recommend that at the next meeting of the Board, in order to implement that action, the Board authorize the presentation of the following resolution as a Board Resolution to the House of Delegates:

Resolution

"WHEREAS: Construction of the new headquarters office building required the Association to borrow $100,000, and

"WHEREAS the interest on this indebtedness over the five (5) year life of the loan approximates $25,000; and

"WHEREAS, a $50 assessment on the active

membership would retire this indebtedness in one year, thereby freeing more than $20,000 in regular income.

"NOW THEREFORE BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE KENTUCKY STATE MEDICAL ASSOCIATION AS FOLLOWS, TO-WIT:

"I. That pursuant to Article 9 of the Constitution an equal per capita assessment of $50 per active member be levied against each component society, and the proceeds used exclusively for the purpose of retiring the mortgage indebtedness on the headquarters building;

"II. That said assessment be due and payable on or before November 1, 1962.

"III. That any person who is an active member of this Association on the date this resolution is adopted, and who fails or refuses to pay the same when due, shall thereafter be ineligible for membership in this Association until the same is paid."

Expediting Appointments of Committees and Councils

The Bylaws Committee was told that the Board of Trustees had referred to it the problem that exists under present procedures in getting the Association's committee activity operating in the fall following the Annual Meeting.

The Bylaws provide that the Executive Committee shall nominate the committees and councils of the Association and that they shall be elected by the Board of Trustees. This procedure usually takes about a month to five weeks after the annual session.

In an effort to speed up this procedure, the Board referred this matter to the Bylaws Committee for study. After careful consideration, the attorney informed the committee that he thinks it is possible, within the present Bylaw structure, for the outgoing Executive Committee to make recommendations to the new Board of Trustees at its reorganizational meeting on the last day of the annual session.

The committee therefore recommends that it be established, as a policy of this Association, that the Executive Committee have these nominations ready for the Board of Trustees at its reorganizational meeting on the last day of the Annual Meeting.

KSMA Committee to Study the Constitution and Bylaws

Cooley L. Combs, M.D., Hazard
Harry Denham, M.D., Maysville
Robert S. Dyer, M.D., Louisville
Bruce Hamilton, M. D., Shepherdsville
George H. Widener, M.D. Paducah
E. C. Strode, M.D., Lexington, Chairman

Recommendations, KSMA Board of Trustees

The KSMA Board of Trustees reviewed this report at the July 26 meeting. Board Action: The report was accepted as presented.

Recommendations, Reference Committee No. 6

Protocol for Committees to Follow

The committee recommends the addition as presented to Chapter 7, Section 4.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Medicolegal Matter

We accept the recommendation of the Bylaws Committee to revise Chapter 6, Section 9 as presented at the top of page 3, report no. 19.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Quorum for KSMA House of Delegates

Referring to Chapter 3, Section 6 of the Bylaws, we accept the report of the committee but recommend that a percentage of qualified delegates be the basis for constituting a quorum due to changes over the years in the total number of delegates in our Association. We therefore recommend changing line 1 to read "forty per cent of qualified delegates" instead of "seventy-five voting delegates."

Mr. Speaker, I move the adoption of this section of the report as amended. (Motion seconded and carried).

Correction of Wording, Chapter 4, Section 2, of Constitution and Bylaws

The Bylaws committee's recommendation that the term "Interim Meeting" be substituted for County Society Officers Conference was approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Grievance Committee Procedures

Chapter 11, Section 10 of the Bylaws was amended by the Bylaws Committee. The Reference Committee accepts the proposed changes but recommends that paragraph 2, page 5, Report No. 19, be changed to read as follows:

"The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees, shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees."

The committee further recommends that the present Section 10 be included in its entirety as paragraph 1 of section 10.

Mr. Speaker, I move the adoption of this section of the report, as amended. (Motion, seconded and carried.

Dues and Assessments

The recommendation on dues and assessments was read and accepted as previously disposed of.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried).

Expediting Appointments of Committees and Councils

This section of the report was read and accepted by the committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Mr. Speaker, I move the adoption of Report Number 19 as a whole. (Motion seconded and carried).

KSMA Interim Meeting Committee

The KSMA Interim Meeting Program Committee held one meeting at Doe Run Inn near Brandenburg.

Attendance by members at this meeting was excellent and the interest in developing a good program for the Owensboro Interim Meeting on Washington's Birthday was most appreciated.

Attendance at the Interim Meeting in Owensboro was excellent. We appreciate the good work of all the members of the program committee.

KSMA Interim Meeting Committee

Howell J. Davis, M.D., Owensboro
Wyatt Norvell, M.D., New Castle
William J. Oldham, M.D., Owensboro
G. L. Simpson, M.D., Greenville, Chairman

Recommendations, KSMA Board of Trustees

The KSMA Board of Trustees reviewed this report at its July 26 meeting. Board Action: The report was approved in full.

Recommendations, Reference Committee No. 6

This report was read and accepted by the committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Report of the Representative on the Kentucky Poison Control Program

A general meeting of the executive committee of the Kentucky Poison Control Program convened at 10 a.m., January 18, 1962.

Discussed at this meeting, along with several other items, was the possibility of a statewide program of a one-day meeting to further the work of the program by informing not only doctors of medicine of the many poisons around but also the many allied men and women of medicine who daily come in contact with the public that is apathy plus, when it comes to preventing poisonings.

An all-day meeting was scheduled at the University of Kentucky Student Union Building on May 23, 1962. This was a well attended meeting by doctors who are in private practice, industrial practice and in many public health fields. Present also were pharmacists and public health employees in various phases of public health work. This proved to be a very informative meeting. Several papers were presented that caused much comment and much discussion, and it was felt by those in attendance that it was a meeting well worthwhile and probably should be repeated on an annual basis.

The only other recent action by this program was approval by the executive committee of the establishment of a new control center at Owensboro.

It is felt by your representative that the Kentucky Poison Control Program is providing a much needed service, that it should be continued and that a representative from the Kentucky State Medical Association should be retained on the executive committee.

Arnold C. Williams, M.D.
KSMA Representative

Recommendations, Reference Committee No. 6

We accept this report and recommend that the work of this program be encouraged.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried).

Mr. Speaker, I move the adoption of this report as a whole. (Motion seconded; carried).

Reference Committee No. 6
Austin Bloch, M.D., Louisville
William Woolfolk, M.D., Owensboro
R. L. Houston, M.D., Eminence
M. Randolph Gilliam, M.D., Lexington
C. J. Shipp, M.D., Greenville, Chairman

REFERENCE COMMITTEE NO. 7

James Ramsey, M.D., Chairman
Miscellaneous Reports

Report of the Representative to Conference of Presidents and Other Officers of State Medical Associations

This conference, as usual, was excellent and well attended. The program participants were George M. Fister, M.D., AMA President-elect, Ogden, Utah; Charles Wilkinson, Head Football Coach, University of Oklahoma; E. L. Wilkinson, President, Brigham Young University; Mrs. Corinne Griffith, Beverly Hills, California, and the Honorable Gordon Allott, U. S. Senator from Colorado.

Charles Wilkinson, chairman of President Kennedy's Physical Fitness Program, was very interesting. Mrs. Griffith advocated abolition of the individual Federal Income Tax, saying that this amounted to $40,000,000,000 annually, but that Federal taxes from other sources amount to $60,000,000,000, which she thinks is enough. Each President and President-elect will find this program well worth attending.

G. L. Simpson, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 7

The contents of this report pertain to the conference of President and Other Officers of State Medical Associations to the 1962 session of the House of Delegates.

It is recommended by the Reference Committee that this report be accepted by the House.

Mr. Speaker, I move the acceptance of this report No. 21. (Motion seconded and carried).

Report of the Representative on the Advisory Committee to the U. of K. Student AMA Chapter

As representative of the KSMA to the University of Kentucky Chapter, Student AMA, I would like to submit my yearly report.

The students greatly appreciated the state's support of their attendance at the national meeting. Although I was unable to attend, the session was apparently quite profitable.

We have had no local get-togethers as of this date.

Richard H. Segnitz, M.D.,
KSMA Representative,
University of Kentucky Chapter,
Student AMA

Recommendations, Reference Committee No. 7

The report describes the activities of the KSMA Representative to the University of Kentucky Chapter, Student AMA, to the 1962 session of the House of Delegates.

It is recommended that this report be accepted by the House of Delegates.

Mr. Speaker, I move the acceptance of Report No. 22. (Motion seconded and carried).

Report of the Representative on the Advisory Committee to the U. of L. Student AMA Chapter

The Chapter has been active again in the usual programs of organizational activities. In addition, they have been operating under a revised Constitution and Bylaws. They participated in regional SAMA meetings and at the national SAMA meeting in Washington, D.C. Three delegates from our Chapter attended. They were active in this meeting particularly in the role of a motion against the King-Anderson type legislation.

It is again a pleasure to report that they have worked in close harmony with the Chapter at University of Kentucky. An excellent rapport exists between the two groups.

It is planned, for the coming year, to have a regional SAMA meeting with the University of Louisville as

host Chapter. The date and details will be confirmed later.

The Kentucky State Medical Association's usual work has been extended to the Chapter and gratefully received in all instances.

It is heartwarming to report that every indication is being shown that our future doctors will be the good citizens medically and civically that the general public has come to expect of the profession.

Hoyt D. Gardner, M.D.,
KSMA Representative,
University of Louisville Chapter,
Student AMA

Recommendations, Reference Committee No. 7

The report describes the activities of the University of Louisville Chapter, Student AMA.

It is recommended that this report be accepted by the House of Delegates.

Mr. Speaker, I move the acceptance of Report No. 23. (Motion seconded and carried).

Report of the McDowell Home Committee

The KSMA McDowell Home Committee met for lunch in Harrodsburg with a committee of business men and women from the city of Danville. Two propositions were considered at this meeting. The first was the endorsement by the KSMA of a play based on the life of Doctor McDowell by Eben Henson of Danville. Most of the committee had previously read the script of this play and thought it was not suitable and had declined to give their approval on this project with the present script. The Committee also declined to underwrite the project to the extent of $3,000. The committee explained to the Danville citizens that it would be happy to endorse this idea with the proper script but had decided it was not within the power of this committee to underwrite the project financially. The Danville citizens understood this.

The second project introduced by the committee was to use money from the Government and from the State to plow up the street in front of the McDowell Home, to raze all the houses on the south side of the street opposite the McDowell Home, to sow the area in grass and to make the McDowell Home one park with Constitution Square which, as you know, is owned by the State. The property included in this plan would belong to the State and would stop at the McDowell Home sidewalk. The Danville citizens thought this was a splendid idea and urged that we all do something about it immediately.

The committee acknowledges with thanks the increased appropriation from the KSMA for running the McDowell Home. The committee reports that because of this increase we have raised the salary of our hostess from $100 to $115 a month.

The committee would like to add to its membership William Knisely, M.D., chairman of the Department of Anatomy, University of Kentucky. Doctor Knisely is much interested in the history of medicine in the State of Kentucky and is undertaking to inform the medical students of this history.

KSMA McDowell Home Committee
Robert Bateman, M.D., Danville
Sterling Coke, Lexington
George Grider, Danville
Laman Gray, M.D., Louisville
E. M. Howard, M.D., Harlan
David Kinnaird, M.D., Louisville
Richard Segnitz, M.D., Lexington
Earl P. Slone, Lexington
Charles A. Vance, M.D., Lexington
Co-Chairman
Francis M. Massie, M.D., Lexington,
Co-Chairman

Supplementary Report

On Friday, June 15, 1962, Sterling Coke and Francis M. Massie, M.D., were invited to Richmond to review the property in the Irvine residence which had belonged to Mrs. Irvine (died 1915) and which had been left to the KSMA. The terms of Mrs. Irvine's will were so complex that the heirs are still protesting the property Mrs. Irvine left. Mrs. Irvine was the granddaughter of Ephraim McDowell, M.D. Much of Doctor McDowell's household furnishings had been stolen.

The mayor of Richmond asked the KSMA to take eight of the portraits of the McDowells and one dining room mirror as a loan from the city of Richmond until the will is cleared, if ever.

These eight portraits are now in the McDowell Home in Danville and will be hung in appropriate places. One is a fine portrait of Mrs. Ephraim McDowell's father, Governor Isaac Shelby.

Recommendations, Reference Committee No. 7

The report describes the activities of this Committee regarding management of the McDowell Home in Danville.

It is recommended that this report be accepted by the House of Delegates.

Mr. Speaker, I move the acceptance of Report No. 26. (Motion seconded and carried).

Report of the Medicolegal Administrator

As Administrator of the KSMA Medicolegal Committee, I would like to report that there has been no activity of this Committee whatsoever.

John D. Gordinier, M.D.
KSMA Medicolegal Administrator

Recommendations, Reference Committee No. 7

Since there have been no activities of this committee, it is recommended that its submitted report be accepted.

Mr. Speaker, I move the acceptance of Report. (Motion seconded; carried).

Report of the Building Committee

Two years ago the House directed the construction of a headquarters building. This committee was directed to advise with the Board of Trustees on construction. We report the completion of this mission.

Our impression of the sentiment of the house was that there should be a new home for the Association. Home has a meaning beyond mere shelter, as a structure of security for the family and as an earnest of stability within the community. We can assure you of the durability of the structure. We hope that you and the community find in it the unpretentious but clean and dignified mien which becomes the character of the good physician.

Financial

Competent architectural advice had led us to anticipate a cost of $100,000 for the building. At the formal letting, six months later, bids ranged from $149,000 to $156,000. Revision of specifications allowed us to negotiate with a reputable builder an adequate building at a contract price of $133,000. We advised the Board that this represented the minimum that would serve the needs of the Association. After studying the data in detail, the Board directed the execution of the contract.

The committee maintained close consultation with the Board regarding financial planning throughout construction. The original committee projection, as submitted to the House, had contemplated mortgage amortization over a 20-year period. Subsequent study

undertaken jointly by the committee and the Board indicated that such financing would result in direct interest costs of $21,000. The least costly financing obtainable was on a six-year mortgage. In a special study, the committee found that this rapid repayment would severely limit all other activities of the Association. The short-term financing was adopted, despite this disadvantage, as best conserving our resources and as permitting the House to weigh the merit of the saving. It is understood that the Board will present specific recommendations to the House regarding the debt.

Community Recognition

The editor and staff of The Journal and the Council on Communications, in their respective spheres, developed exceptionally effective campaigns for publicizing the home-building by the Association. Maximum coverage was obtained in both the metropolitan and rural press, and the dedication issue of The Journal received wide acclaim among the authorities on the medical press.

Acknowledgement

We would have been sorely pressed but for the generous help of all to whom we looked for guidance. The Board of Trustees has been most kind and patient in helping us to walk the narrow line between short-sighted niggardy and wasteful profligacy. Other officers and employees of the Association, as well as individual members, have generously contributed their time and wisdom.

Recommendation

That this committee be discharged.

KSMA Building Committee
N. Lewis Bosworth, M.D., Lexington
Hoyt D. Gardner, M.D., Louisville
G. F. Brockman, M.D., Greenville,
Chairman

Addendum

This Association has recognized the capability of N. Lewis Bosworth, M.D., as chairman of the Council on Communications, and of Hoyt D. Gardner, M.D., as secretary and director of KEMPAC. The great amount of time and energy expended, the effective service rendered and the dedication of these men demonstrated in the past three years in bringing our new building into being is a contribution to our Association which is far above what one would normally expect and should command our lasting appreciation.

Recommendations, KSMA Board of Trustees, July 26, 1962

The KSMA Board of Trustees reviewed this report at its July 26 meeting.

Board Action: The report was approved as presented and it was recommended that the Building Committee be discharged, as requested in its report, with the profound thanks of the Board of Trustees for its excellent work.

Further Recommendation of the Board of Trustees relating to the Building Committee

It was noted in the report of the Building Committee to this House tonight that the Building Committee recommends that it be disbanded. After further consideration, the Board of Trustees recommends that the Building Committee recommendation on this one point not be accepted and that the committee be continued one more year. The Board makes this request because it feels that the Building Committee is more familiar with the situation and that it is in the strongest position to protect the Association's interest in seeing that all warranties and commitments are faithfully discharged.

Recommendations, Reference Committee No. 7

This report describes the activities of this Committee and includes financial data concerning the new KSMA building and gratefully acknowledges the assistance that they have received from other members of the Board of Trustees.

It is recommended that this report be accepted by the House of Delegates with the exception of the part concerning discharge of the Building Committee. It is recommended that this Committee continue its function for a period of one year.

Mr. Speaker, I move the acceptance of Report No. 28 with the exception of the Committee's recommendation of discontinuing the Building Committee. (Motion seconded and carried).

Report of the Woman's Auxiliary

In this, the 39th year, the Woman's Auxiliary to the Kentucky State Medical Association has shown evidence of progress in growth and service. "Speak Your Beliefs in Deeds," the theme of our national president, has been our guide throughout the year in all of our undertakings and as president I am pleased to present the following report.

American Medical Education Foundation donations showed an increase of $205.26 over last year with total contributions amounting to $1,469.26, which includes $100 from the State Auxiliary plus the sale of memorial, appreciation and all-purpose cards, Christmas cards and AMEF playing cards and contributions from 16 of the 24 counties. Special AMEF exhibits were used at the State Board meeting and convincing letters were sent to all county presidents and chairmen to encourage special fund raising projects.

Bulletin subscriptions have decreased to 61 from 100 last year and 153 in the previous year as a result of neglect to renew subscriptions. Most of the state board members subscribe and all the county presidents, and some chairmen of the county auxiliaries which the state president visited subscribed after they learned of the importance of the material and the use which can and should be made of it. The President's Page and state reports were found most helpful to members.

Speakers on civil defense were on the programs of five auxiliaries and many members attended survival and first aid courses, and a Symposium on Thermonuclear Disaster at the University of Kentucky. Many copies of fallout shelter booklets were distributed, and meetings were held to plan home emergency care instruction in cooperation with civil defense directors. Other counties met with schools for practice alerts, took part in Pantry Drive, formed civil defense committees with community representatives and met with planning committees.

Community Service projects and activities among auxiliary members are many and varied, either as a group or as individuals working through other organizations. Among these activities were programs to interest others in health problems of the aging; recreation and entertainment of senior citizens; programs on medical care costs; medicine as a career in schools through guidance teachers; and Health Essay Contests. Volunteer service and contributions were made during the year to various organizations such as PTA, Girl Scouts, hospitals, library board, Homemakers, Woman's Clubs, Community Chest, Heart Fund, Polio Foundation, Blood Bank, Crippled Children, Cerebral Palsy, Cancer, Mental Health, T. B., Retarded Children and student education. Two films were used by the state president with senior citizens church groups —"Old Man Young" and "The Medicine Man" obtained from the AMA film library. Also literature obtained from AMA and KSMA was presented.

The state auxiliary presents a health citation *award* each year to the lay person or organization who renders outstanding service in the field of health, each county submitting a candidate chosen from those submitted by other organizations in the community. At our September 1961 Convention, the award was given to Mr. and Mrs. Joseph Castlen, Owensboro, for their work with retarded children, and a token gift of $15 accompanied the citation.

Health Careers scholarships have been given in five counties, 12 loans in the field of nursing amounting to $2,270, two in X-Ray Technology, one in Instructor Education for $200 and two uncommitted in the amount of $800, making a total of $3,270. Seven Health Career Clubs have been organized with 25 club members entering school for study in a health career. Career Days were sponsored by 12 counties and many films on various professions were used. Recruitment projects included hospital tours, Kentucky Health Council programs, preparation and mailing of booklets listing service to all loans, agreements, etc., to all counties. The state auxiliary offers two scholarship loans annually and renewal or additional allotments to presently sponsored students, to assist in any career in a health discipline area. This year a total of $1,150 has been loaned to four students.

The *State Historian* has brought the files up to date and filed all pertinent correspondence and reports, placing them in the new auxiliary room in the new Kentucky State Medical Association headquarters building. The KSMA also finances the printing of the Directory, Convention Program, Blue Grass News and official stationery.

Legislation has been our top priority project this year as it has been and no doubt will continue to be. The State President has met with the KSMA Board of Trustees and the Legislative Steering Committee and four auxiliary members. In addition, the president took part in speaking engagements for programs of the annual meetings of the 15 Districts which were keyed to the subject of preserving our system of private medicine. Several auxiliary members attended the fifth annual KSMA dinner honoring Kentucky senators and congressmen, their wives and office personnel, at the Mayflower Hotel in Washington, D.C., in March with the KSMA officers and trustees. The trip included a tour of our AMA Washington office, Senate and House offices of each of our two senators and eight representatives.

A WHAM Campaign Workshop dinner was held in February in Owensboro with 19 counties, 12 auxiliaries and seven members-at-large represented. WHAM kits were distributed and an extensive letter-writing campaign was pursued as a result. Also the KSMA Interim Meeting was well attended by auxiliary members.

A radio program was given in Owensboro by the president and representatives of other organizations, including the DAR, League of Women Voters, and AAUW in the form of a round table discussion of the provisions of the King-Anderson Bill and the Kerr-Mills Law. Also the state president visited 10 county auxiliary meetings talking on legislation and distributing Ronald Reagan records. All counties have used the record extensively and have written many letters and obtained resolutions from other organizations.

Our Membership as of May 1, 1962, shows an increase of 15 with a total of 1,302. However, members-at-large have decreased from 140 to 132 and two counties have disbanded. We had hoped to be able to report two new auxiliaries, one reorganized, but dues were never recieved, although organizational meetings were held. Most of our county organizations have less than 50 members, the smallest having nine, and two counties have over 100 members and only one is between 50 to 100. It is in the small organizations where problems arise because of too much load on a few. Loss of membership at large is probably due to late dues notices because of change of treasurers, although our hard-working coordinator of members-at-large sent out 579 letters urging renewals, and brought up our total membership at large to within eight of last year.

To enlist and hold the interest of the membership at large, our membership chairman mailed pamphlets, "Helping Those Who Need Help," to alert them to the danger of the impending legislation on medical care of the aged and to request them to so inform themselves that they would be able to speak up for medicine before other organizations or across the bridge table.

Several counties had programs on mental health: "Mental Health and Religious Experience" and film, "Old Man Young." Donations and memberships in mental health groups furnished social psychiatric workers in the community. Donations were made to state mental hospitals, members served on mental health boards, sent Christmas gifts to mental hospitals, and held benefit bridge parties for retarded children's funds.

The state auxiliary *program* stressed the national goals in Legislation, Health Careers, AMEF, Community Service, Program and Public Relations. Packaged programs were made available for use in the counties. Operation Coffee Cup continued to be the most popular program. Public Relations was the theme of the state auxiliary for the year with a panel, "Speaking Up For Medicine," on radio, TV, newspaper and in the community being given at the Fall Board meeting by representatives from each media and followed by a question and answer period. Our goal—to promote better understanding and friendlier relationship between our organization and the different media and thereby gain more favorable publicity and consequently better public relations and a more accurate image. All counties were given handbooks and guides to better public relations urging the importance of publicity of worthwhile projects.

Safety was implemented in many ways through baby-sitting courses set up throughout the state. A seat belt booth, co-sponsored with our parent organization, at the annual state meeting, met with great approval and brought much stimulus to the Kentucky medical safety program.

President's Report: As president-elect and president, I attended the Annual Conventions of the Woman's Auxiliary to the American Medical Association in Miami Beach, in New York and in Chicago; two fall Conferences for Presidents and Presidents-elect in Chicago; the Kentucky Rural Health Conference at Kentucky Dam Village and in 1961 at Morehead College; AMA Regional Conference on Legislation at French Lick, Indiana; meeting for organizing Boyle County Auxiliary in Danville; Senior Day Tea in Louisville; two Fall Conferences of the Kentucky State Auxiliary Board of Directors, one in Frankfort and one in Louisville; two Spring Board meetings, one in Lexington and one in Owensboro; House of Delegates meetings of the Indiana State Medical Auxiliary at South Bend and at Elkhart; the West Virginia State meeting at White Sulphur; the Ohio State meeting at Columbus; KSMA Interim Meeting in Owensboro; meeting of Nurses Association in Louisville; dedication of the KSMA building; five meetings of the KSMA Steering Committee in Louisville; one meeting of the Board of Trustees of the KSMA in Louisville; Doctor's Day celebration in Owensboro; and as a delegate sent by KSMA to the fifth annual good will trip to Washington to visit Kentucky congressmen and senators. I presided at four State Auxiliary Board meetings, a called Executive Board meeting in Louisville, the WHAM Campaign Workshop and the State Convention in Louisville, September 18-19, 1962.

As a member of the KSMA Speakers' Bureau, I spoke on legislation at district meetings at Bowling Green, Hopkinsville, Elizabethtown and Louisville. Other district meetings attended were at Henderson, Somerset and Owensboro and county auxiliary meetings at Corbin, Paducah, Henderson, Harlan, Madisonville, Bowling Green and Owensboro, where I addressed the members and installed officers. Nine other special committee meetings were held in the state during the year.

I was a participant in the "In Memoriam" service at the National Convention in Chicago, presented the Presidential Report for the State of Kentucky and contributed newspaper clippings from Kentucky auxiliaries for the Publicity clinic.

During the year the president wrote an article for each issue of the Blue Grass News, one for the National Bulletin, one for the President's Page of the KSMA Journal, and a Report of the Kentucky Auxiliary activities for the National Archives and to be published in Minutes and Reports, completed State's Reports for the National Auxiliary and sent out 12 letters of communications and news letters of instruction to State Board members.

National officers and chairmen do a magnificent job of giving ideas and know-how to the state organization through printed material and the Fall Conference in Chicago. I only wish that we could do as well for our counties. The KSMA officers, Board of Trustees, Advisory Board, and Executive Staff have been most helpful, cooperative and encouraging in all of our undertakings. Much praise is due to each member of the State Board for her wonderful cooperation and to each county auxiliary member who contributed so willingly to make this report possible. It has been an inspiration and a pleasure to have been a part of everything and everyone with whom I have come in contact during my year as State President, and my many thanks to all of them.

Mildred B. Morford
President, Woman's Auxiliary
to the Kentucky State
Medical Association

Recommendations, Reference Committee No. 7

This report describes the statewide activities of the Woman's Auxiliary to the Kentucky State Medical Association.

It is recommended that this report be accepted by the House of Delegates and that the Woman's Auxiliary should be commended for their dedicated work.

Mr. Speaker, I move acceptance of Report No. 32. (Motion seconded and carried).

Report of the Representative, Advisory Committee on Maternal and Child Health, State Department of Health

As far as we are able to determine, there was only one meeting of this committee held this year and we were unable to attend.

We have, therefore, no report to make.

William H. Parker, M.D., Owensboro
KSMA Representative

Recommendations, Reference Committee No. 7

It is recommended that this report be accepted by the House of Delegates.

Mr. Speaker, I move the acceptance of Report No. 33. (Motion seconded; carried).

Report of Memorials Commission

Due to conditions beyond the control of both our commission and the Board of Trustees, our group was activated late in the year. Illness prevented us from holding the one meeting we had an opportunity to schedule.

In authorizing the activation of this commission, the House of Delegates set forth three obligations. They were that a Memorials Commission be established to:

1. Accept gifts to the Association,
2. Acknowledge generosity in the name of the Association, and
3. Preserve or use contributions according to the wishes of the donor.

Our commission fully subscribes to these principles and deeply regrets the manner in which circumstances have developed.

This commission would recommend that it be continued and that the Board of Trustees, when it makes the 1962-63 appointment, increase the number of our personnel from three to five.

KSMA Memorials Commission
C. C. Howard, M.D., Glasgow
Carlisle Morse, M.D., Louisville
J. Duffy Hancock, M.D., Louisville,
Chairman

Recommendations, KSMA Board of Trustees

The KSMA Board of Trustees reveiwed this report at the July 26 meeting.

Board Action: The report was accepted as presented.

Recommendations, Reference Committee No. 7

Description of the duties of the Memorial Commission.

It is recommended that this report be accepted by the House of Delegates.

Mr. Speaker, I move the acceptance of Report No. 35. (Motion seconded and was carried).

Resolution K
Fayette County Medical Society

"WHEREAS, membership of the KSMA is becoming increasingly cognizant of its Woman's Auxiliary as an effective and interested source of help, and

"WHEREAS, the very great value of the Woman's Auxiliary to this organization became more than ever apparent during this past year in which their efforts, as much as ours, helped in the defeat of the King-Anderson type legislation, THEREFORE BE IT RESOLVED

"That this House of Delegates express its deep gratitude to and its sincere pride in the Woman's Auxiliaries both on a State and local level, and, BE IT FURTHER RESOLVED

"That the future events affecting this Association will require their increasing dependence on them both individually and collectively."

Recommendations, Reference Committee No. 7

Contents of the report are an expression of gratitude and pride in the Woman's Auxiliary by the Fayette County Medical Society.

It is recommended that this report be accepted by the House of Delegates.

Mr. Speaker, I move the acceptance of Resolution K. (Motion seconded; carried).

Mr. Speaker, I move the acceptance of this report as a whole. (Motion seconded and passed).

Reference Committee No. 7
James Ramsey, M.D., Frankfort, Chairman
Donald Chatham M.D. Shelbyville
J. M. Hunt, M.D., Wickliffe
J. H. Saunders, M.D., Lexington
James Riley, M.D., Louisville

Unfinished Business

It was stated that there was no unfinished business at this time. The Speaker expressed appreciation for the spirit of cooperation and good will of the delegates.

Election of Officers

The Speaker then called for the report of the Nominating Committee which was presented by the Chairman, Russell L. Hall, M.D., Prestonsburg. Doctor Hall read the following list of nominations for the positions to be filled which were as follows:

President Elect	George P. Archer, M.D., Prestonburg
Vice-Presidents	
Central	Alfred O. Miller, M.D., Louisville
Eastern	Hugh Mahaffey, M.D., Richmond
Western	Joe Miller, M.D., Benton
AMA Delegate	Robert C. Long, M.D., Louisville
AMA Alternate Delegate	J. Thomas Giannini, M.D., Louisville
Speaker	Garnett J. Sweeney, M.D., Liberty
Vice-Speaker	George F. Brockman, M.D., Greenville

After each nomination was presented, the Speaker called for nominations from the floor but none were made and each nominee was elected individually without dissent.

Doctor Archer then resigned his position as AMA Delegate and the Nominating Committee submitted the name of Wyatt Norvell, M.D., New Castle to fill out his unexpired term. No additional names were submitted, and Doctor Norvell was elected.

The Chairman then submitted the following nominations to the office of trustee:

First District	O. Leon Higdon, M.D., Paducah
Third District	Gabe A. Payne, Jr., M.D., Hopkinsville
Fourth District	Dixie F. Snider, M.D., Springfield
Twelfth District	Thomas O. Meredith, M.D., Harrodsburg
Fourteenth District	William C. Hambley, M.D., Pikeville

The same procedure followed in electing the general officers was followed in the election of the trustees, and there being no nominations from the floor, the above-named nominees were elected.

The three past presidents of Eastern Kentucky were asked to escort the new president-elect to the rostrum. Doctor Archer made brief remarks following a standing ovation.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted at this time and received for information only:

Everett H. Baker, M.D., Louisville
William C. Buschemeyer, M.D., Louisville
William H. Cartmell, M.D., Maysville
Delmas M. Clardy, M.D., Hopkinsville
Morris M. Garrett, M.D., Covington
Leon Hidgon, M.D., Paducah
Hubert C. Jones, M.D., Berea
John S. Llewellyn, M.D., Louisville
Ralph D. Lynn, M.D., Elkton
Oscar O. Miller, M.D., Louisville
J. Vernon Pace, M.D., Paducah
Gerald M. Peterson, M.D., Louisville
John T. Walsh, M.D., LaGrange

Election of 1963 Nominating Committee

The nominating committee to serve at the 1963 Annual Meeting was duly elected as follows:

Ballard Cassady, M.D., Pikeville
James B. Douglas, M.D., Louisville
Carl Fortune, M.D., Lexington
Gabe A. Payne, M.D., Hopkinsville
Loman C. Trover, M.D., Madisonville

At this time, David M. Cox, M.D., Louisville was installed as president by the chairman of the Board of Trustees, Wyatt Norvell, M.D., New Castle, who administered the oath of office.

The new president's first official act was that of presenting the past president's key to the retiring president, G. L. Simpson, M.D., Greenville.

Doctor Overstreet thanked the House for its attentiveness during both sessions. There being no further business, a motion was made, seconded and carried that the 1962 meeting of the House of Delegates adjourn at 9:30 p.m.

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ORGANIZATION SECTION

KSMA Interim Meeting Committee Plans Excellent Program

An excellent program for the 1963 Kentucky State Medical Association Interim Meeting was planned at a meeting of the Interim Meeting Program Committee at Lexington, October 31. KSMA President David M. Cox, M.D., Louisville, presided at the session attended by members of the Committee and by Mrs. James Sears Rich, president of the Woman's Auxiliary to KSMA.



Doctor Davis

The Interim Meeting will be held Thursday, March 7, at the Town and Country Restaurant, Park Hills, Covington. A block of rooms for those attending has been reserved at the Lamplighter Motor Inn, Covington.

Milton V. Davis, M.D., Dallas, Texas, secretary-treasurer of AMPAC, is to be one of the headline speakers at the meeting. His topic will be: "Political Effectiveness."

Additional speakers and more details of the program will be announced in the January issue of The Journal.

Doctor Davis is a graduate of Southwestern Medical College at Dallas and a specialist in thoracic and cardiovascular surgery. He served in the U. S. Army and Air Force Medical Corps for two years. At the present time he is clinical assistant professor of thoracic surgery at the University of Texas Southwestern Medical School. He is first vice president of the Texas Chapter of the American College of Chest Physicians.

Dependents of Extendees Are Still Eligible for Medical Care

A recent letter from the Office of the Surgeon General, U. S. Army, notes that certain servicemen have been retained on active duty beyond their normal date of expiration. This means that the dependents of these servicemen are still eligible for medical care under the "Dependents Medical Care Program" even though some of them will possess outdated privilege cards (DD Form 1173).

Should medical care be needed prior to receiving a new privilege card, the dependent has been instructed to explain the situation to the physician and hospital authorities. He has been advised to present, if available, some tangible evidence, such as allotment checks, official orders, etc., to help support his claim of continued eligibility.

Service personnel will be advised that it is their responsibility to take necessary action to "update" the evidence of dependents' eligibility. Physicians and hospitals are encouraged to exercise patience and understanding during the next several months when their services are requested by dependents of these extendees.

It is emphasized, however, that no claims may be processed for payment unless the dependent has provided a valid DD Form 1173 or a statement of eligibility as required by the present contract.

Doctor Cartmell Named to Head Ky. Physicians Mutual

W. H. Cartmell, M.D., Maysville, has been elected president of the Kentucky Physicians Mutual Inc., (Blue Shield). He succeeds John Dickinson, M.D., Glasgow, as president.

Other Blue Shield officers are: Delmas M. Clardy, M.D., Hopkinsville, vice president; Joe P. Sanford, Louisville, secretary; Branham B. Baughman, M.D., Frankfort, treasurer. D. Lane Tynes is executive director.

The Kentucky Physicians Mutual is in its 14th year. Doctor Cartmell has been chairman of the finance committee for several years and has served as vice president.

Postgraduate Teaching Teams Organized by TB Groups

Two postgraduate teaching teams—one at Louisville and one at Lexington—have been organized by the Kentucky Tuberculosis Association and the Kentucky Thoracic Society. They are available for conferences, county society or hospital staff meetings, and specially scheduled teaching sessions in community hospitals.

Each team includes a surgeon competent in both general and thoracic surgery and an internist with a subspecialty interest in the field of pulmonary disease. Both teams are prepared for from one to three hour sessions. Cases of pulmonary disease presented by a community's physicians to the teams would be discussed as to diagnosis, differential diagnosis, complications, treatment and prognosis.

Any group wishing to engage the services of a team should write to the Educational Committee of the Kentucky Thoracic Society, 1480 South Third St., Louisville 8, Ky. Expenses are paid by the Kentucky TB Association. A two-months' notice in advance of a meeting is requested.

163 from 36 Kentucky Counties At Rural Health Conference

Thirty-six Kentucky counties were represented at the 10th annual Kentucky Rural Health Conference October 25 at Cumberland Falls State Park. A total attendance at the Conference of 163 was chalked up, with 89 attending from the 24 southeastern counties in the Cumberland Falls area. (See pictures on this page.)

James C. Salato, M.D., Columbia, was reelected chairman of the Kentucky Rural Health Council which sponsored the Conference. Miss Viola Hansen, Kentucky Extension Service, was elected vice chairman, and William Padon, Kentucky Farm Bureau, secretary-treasurer.

Russell E. Teague, M.D., Kentucky's commissioner of health, addressed the luncheon session in place of Governor Bert T. Combs who was scheduled to make an address but was unable to attend.

Among the other speakers were: Willis A. Sutton, Jr., Lexington, Department of Sociology, University of Kentucky; John D. Whisman, Frankfort, Kentucky Area Redevelopment administrator; David M. Cox, M.D., Louisville, president of the Kentucky State Medical Association; William R. Willard, M.D., Lexington, dean of the U. of K. College of Medicine.

A panel which included physicians, a dentist, a pharmacist and a registered nurse presented "A Profile of Health Services and Resources in the Cumberland Falls region. There were three audience participation discussions, meeting simultaneously.

Joint Blood Council Dissolves

The Joint Blood Council, Inc., is being dissolved since it is deemed to have achieved its major goal—coordination of blood programs. Plans are underway for its five component institutions to continue liaison of blood interests through advisory representatives who will meet occasionally as necessary.

The Joint Blood Council was formed in 1955 by the American Medical Association, American National Red Cross, American Hospital Association, American Association of Blood Banks and American Society of Clinical Pathologists. The Council was praised for its accomplishments by Gunnar Gunderson, M.D., Council president and a past president of the AMA, and by other individuals and groups.

Blue Shield Makes Top Payments

The $476,926,917 paid out for surgical-medical care by the 75 Blue Shield Plans of North America during the first half of 1962 represents a record high for a six-month period, according to John W. Castellucci, executive vice president of the National Association of Blue Shield Plans.

This figure exceeds the 1961 figure for the similar six-month period by $60,000,000, according to Mr. Castellucci. He said the record payment represents more than 91% of the total income of the Plans, and noted that the payments in the first half of 1962 were more than in the entire year of 1956.

1962 Ky. Rural Health Conference Story Told in Pictures



In the top picture, left to right, 1962-63 officers of the Kentucky Rural Health Council: James C. Salato, M.D., chairman; Miss Viola Hansen, State Extension Service, vice chairman, and William Padon, Kentucky Farm Bureau, secretary-treasurer. (See story on this page).

Speakers at the Conference are shown in the second picture, left to right, John D. Whisman, Kentucky Area Redevelopment administrator; Robert Johnson, director, state and local services, U. of K. Medical Center, who presided at the morning session; Willis A. Sutton, Department of Sociology, U. of K., and David M. Cox, M.D., president of the Kentucky State Medical Association.

Russell E. Teague, M.D., Kentucky health commissioner, and William R. Willard, M.D., dean of the U. of K. Medical Center, who were both Conference speakers, are pictured in the third photograph with members of a panel who discussed Health Services and Resources of the Cumberland Falls Region. Top row, left to right, R. E. Pennington, M.D., Dean Willard and Doctor Teague. Bottom row: Orville Vallou, D.D.S.; Miss Rebecca Forrest, R.N.; M. A. Shepherd, M.D.; and Joseph A. Bondurant, pharmacist.

John E. Dawson, M.D., Newport obstetrician and gynecologist, was advanced from senior grand warden to deputy grand master at the recent Louisville session of the Masonic Grand Lodge of Kentucky.

Daniel L. Sexton, M.D., Succeeds Dr. McCarty as SMA Head

Daniel L. Sexton, M.D. St. Louis, Mo., was elected president of the Southern Medical Association at the 56th annual meeting at Miami Beach, Fla., November 12-15. Doctor Sexton succeeds A. Clayton McCarty, Louisville. Doctor McCarty was named to the board of trustees of the Association.



Doctor McCarty

Sam A. Overstreet, M.D., Louisville, was named councilor for Kentucky, succeeding J. Duffy Hancock, M.D., Louisville. Doctor Overstreet is Editor of The Journal of the Kentucky State Medical Association. During the President's Luncheon Doctor Hancock received a certificate of appreciation along with other councilors whose terms were expiring in 1962.

Howard Holley, M.D., professor of medicine and head of the Division of Hematology at the University of Alabama Medical Center, Birmingham, received the Seale Harris Award. The Distinguished Service Award went to Wilburt C. Davison, M.D., Durham, N. C., former dean and professor of pediatrics, Duke University School of Medicine.

Among other Kentuckians prominent at the session were: W. Vinson Pierce, M.D., Covington, named secretary of the Urology Section, and Ralph M. Denham, M.D., named chairman of the Medicine Section. Andrew H. Moore, M.D., Lexington, was named assistant secretary of the Section on Plastic and Reconstructive Surgery.

Southern Medical Assn. Meeting Attracts Many Ky. Physicians

A number of Kentucky physicians attended the 56th annual meeting of the Southern Medical Association at Miami Beach, Fla., November 12-15. According to registration data supplied by the SMA these included:

John D. Allen, M.D., and Mrs. Allen, Louisville
M. L. Barnes, M.D., and Mrs. Barnes, Louisville
C. M. Brassfield, M.D., and Mrs. Brassfield, Elizabethtown
W. P. Blackburn, M.D., and Mrs. Blackburn, Frankfort
Carl J. Brueggeman, M.D., Covington
George N. Burger, M.D., and Mrs. Burger, Covington
Boyd Caudill, M.D., and Mrs. Caudill, Lawrenceburg
E. S. Carter, Jr., M.D., Hazard
B. F. Combs, M.D., Lexington
Raymond Grant Culley, M.D., Ashland
Joseph F. Daugherty and Mrs. Daugherty, Florence
George Gumbert, M.D., and Mrs. Gumbert, Lexington
John S. Harter, M.D., and Mrs. Harter, Louisville
Fred C. Hauck, M.D., and Mrs. Hauck, Owensboro
George J. Hermann, M.D., and Mrs. Hermann, Ft. Thomas
E. K. Hughes, M.D., Louisville
David H. Johnston, M.D., Lexington
Ullin W. Leavell, M.D., Lexington
Paul F. Maddox, M.D., and Mrs. Maddox, Campton
T. R. Marshall, M.D., and Mrs. Marshall, Louisville
Robert J. McGrath, M.D., Louisville
Beverley Mead, M.D., Lexington
T. O. Meredith, M.D., and Mrs. Meredith, Harrodsburg
Andrew M. Moore, M.D., Lexington
James R. Mayers, M.D., and Mrs. Mayers, Middlesboro
Rene Menguy, M.D., Lexington
Sam A. Overstreet, M.D., and Mrs. Overstreet, Louisville
Leland E. Payton, M.D., Lynch
W. Vinson Pierce, M.D., and Mrs. Pierce, Covington
George O. Roth, M.D., Florence
Gladys L. Rouse, M.D., Florence
C. C. Rutledge, M.D., Hazard
James E. Ryan, M.D., and Mrs. Ryan, Louisville
Allen M. Sakler, M.D., and Mrs. Sakler, Louisville
John J. Salter M.D., and Mrs. Salter, Harlan
M. W. Schell, M.D., Owensboro
J. Schickel, M.D., and Mrs. Schickel, Burkesville
L. Jack Scott, M.D., and Mrs. Scott, Bowling Green
Truman S. Smith, M.D., Madisonville
F. C. Spencer, M.D., Lexington
Charles B. Spalding, M.D., Bardstown
Donald M. Stevens, M.D., and Mrs. Stevens, Highland Heights
M. G. Veal, M.D., Henderson
William W. Wainer, M.D., Providence
Herman Wing, M.D., Louisville
T. Julian Wright, M.D., and Mrs. Wright, Stanford

W. B. Saunders Co. Announces $15,000 Writing Grant

To mark its 75th anniversary in 1963, the W. B. Saunders Co., Philadelphia, medical and scientific publishers, is offering a $15,000 medical writing award.

Purpose of the grant is to provide financially for a year's leave of absence for a distinguished investigator who has been doing significant biomedical laboratory research over the past several years and would like to have time to prepare his work in monographic form. Recipient of the award would be free to write either a book or a series of journal articles.

Applications may be submitted informally to Robert F. Loeb, M.D., chairman of the selection committee of 20, in care of the W. B. Saunders Co., West Washington Square, Philadelphia 5, Pa., between January 1 and May 1, 1963. Decision will be made by August 1 and formal presentation, in October 1963.

Philip B. Schworer, M.D., has entered general practice at Florence, Ky. Doctor Schworer is a 1960 graduate of the University of Cincinnati School of Medicine and interned at St. Elizabeth Hospital, Covington, Ky. He previously practiced at South Fort Mitchell.

Miss Walters Elected President of Ky. Registered Nurses

Miss Mary Margaret Walters, Louisville, director of nurses, District 2 State Tuberculosis Hospital, was elected president of the Kentucky State Association of Registered Nurses at the annual meeting of the Association at Louisville October 17-19.



Miss Walters

Other officers are: Vice president, Miss M. Sue Kern, director of nursing, University of Kentucky Hospital, Lexington; treasurer, Miss Lillian E. Shacklette, Louisville Veterans Hospital; directors: Miss Betty McKibbin, director of nursing, District 6 State Tuberculosis Hospital, Glasgow, and Miss Nadine Turner, director of in-service education, Daviess County Hospital, Owensboro.

At the meeting the Association made plans to: Push for state legislation requiring a license for any person practicing nursing for pay; ask the American Nurses Association to set up machinery for evaluating nursing service aimed at raising standards; work through a special committee on professional practice to enforce ethical, professional and legal standards of nursing service.

The Association will hold its 1963 annual meeting at the Phoenix Hotel, Lexington, October 16-18.

Kentucky Medical Assistants Plan First State Meeting

The Kentucky State Association of Medical Assistants has scheduled its first annual meeting in May 1963 in Louisville. Plans are now being considered and a detailed announcement will be made later.

The Association received official approval from the Kentucky State Medical Association House of Delegates to organize on a statewide basis in September 1961 and on April 15, held its organizational meeting. A charter for the Kentucky group from the AAMA was received at the sixth annual convention of that group at Detroit, Mich., September 28, 1962. (See picture on this page.)

Medical advisors to the new association are: Marion F. Beard, M.D., Louisville chairman; Murvel Blair, M.D., Frankfort; Jack Chumley, M.D., Louisville; Robert C. Long, M.D., Louisville and James Ramsey, M.D., Frankfort. Doctors Beard and Blair are serving three-year terms; Doctors Chumley and Long, two-year terms and Doctor Ramsey, one year. More information about the organization may be obtained from Mrs. Louise Hawkins, KAMA president 814 Medical Towers, Louisville 2, Ky. The national organization has 10,000 members in 35 states.

Doctor Olash Makes Address

F. Albert Olash, M.D., Louisville, internist and instructor in medicine at the University of Louisville School of Medicine, was one of the speakers at Alumni Institute Medical Symposium of the University of Scranton, Scranton, Pa., November 17.



Officers and members of the Kentucky State Association of Medical Assistants are pictured here at the sixth annual convention of the American Association of Medical Assistants at Detroit, September 28, where the Kentucky group received its charter: Seatd from left to right, Mrs. Nancy Tatlock; Mrs. Wanda Taylor, historian; Mrs. Eleanor Allen and Miss Barbara Smith. Standing, left to right, Mrs. Virginia Applegate, corresponding secretary; Miss Dorothy Downs, vice president; Miss Catherine Corbin, recording secretary; Mrs. Louise Hawkins, president (holding charter); Mrs. Phoebe Faust, treasurer; Mrs. Margaret Glass; Mrs. Ernestyne Gates, membership chairman. (See story on this page.)

Doctor Coe Reelected To Head Louisville Heart Group

Walter S. Coe, M.D., was reelected president of the Heart Association of Louisville and Jefferson County at the 11th annual membership meeting November 14. Other officers reelected include: Jack Chumley, M.D., president-elect; George W. Pedigo, M.D. vice president; Kenneth P. Crawford, M.D., secretary, and M. L. McMakin, treasurer.

Robert S. Dyer, M.D., J. Murray Kinsman, M.D., Woodford B. Troutman M.D., and Morris M. Weiss, Sr., M.D., were renamed to the board of directors.

Doctor Dyer was among those receiving certificates of appreciation for "distinguished service" as board of directors' members for two terms.

John J. Sampson, M.D., San Francisco, president-elect of the American Heart Association, was the featured speaker. He is clinical professor of medicine at the University of California School of Medicine.

U. of K. College of Medicine Names Four to Faculty

John W. Greene, Jr., M.D., has been named chairman of the Department of Obstetrics and Gynecology of the University of Kentucky College of Medicine, Lexington.



Doctor Greene

Doctor Green is a 1952 graduate of the University of Pennsylvania School of Medicine. He has been assistant professor of obstetrics and gynecology at the University of Pennsylvania since 1959 and has also served as attending obstetrician and gynecologist at the University's Hospital at Philadelphia.

John Jarnefelt, M.D., has been appointed associate professor of the Department of Pharmacology at the U. of K. College of Medicine. Takashi Sasaki, M.D., has been named a visiting professor in the Department of Physiology. Paul Melius has been named visiting professor in the Department of Biochemistry.

Louisville Surgeons Named

Laman Gray, M.D., and John Harter, M.D., were named titular members and J. Duffy Hancock, M.D., was advanced from associate to titular member of the American Chapter of the International Society of Surgeons at a meeting October 18 at Atlantic City during the meeting of the American College of Surgeons. All are from Louisville.

Six Louisville Doctors Join KSMA

The Kentucky State Medical Association reports six new members, all of Louisville, as follows: Carmine Scalzitti, M.D.; Stanley Collis, M.D.; Daniel Stowens, M.D.; Philip Hulsman, M.D.; E. B. Schoenbachler, M.D., and Craig Wetzelberger, M.D.
Organization

Letters To The Journal

Doctor Walton Thanks KSMA

To the Editor:

Please let me take this opportunity to express to each of you my heartfelt thanks for the wonderful honor paid me by the Kentucky Medical Association when you chose me as the "General Practitioner of the Year."

It was the crowning event in my 54 happy years in the medical profession. On two occasions my friends and neighbors in my home town have named me "Man of the Year." For this, too, I am grateful. But I can truthfully say that there is no satisfaction to be found anywhere to compare with the recognition and approval of my colleagues in the medical profession as displayed at the recent 1962 convention of the Kentucky Medical Association.

At the age of 80, I am too old to suffer from the false vanity of thinking I deserve this great honor. In fact, I am sure that your selection of me was the result of a faulty diagnosis of the problem on your part.

Let me hasten to add, however, that after receiving your kind treatment, I must admit that your prescription was just the medicine to bring a large measure of happiness to an old man. The prognosis in my case is extremely favorable.

My sincere thanks to you, doctors.

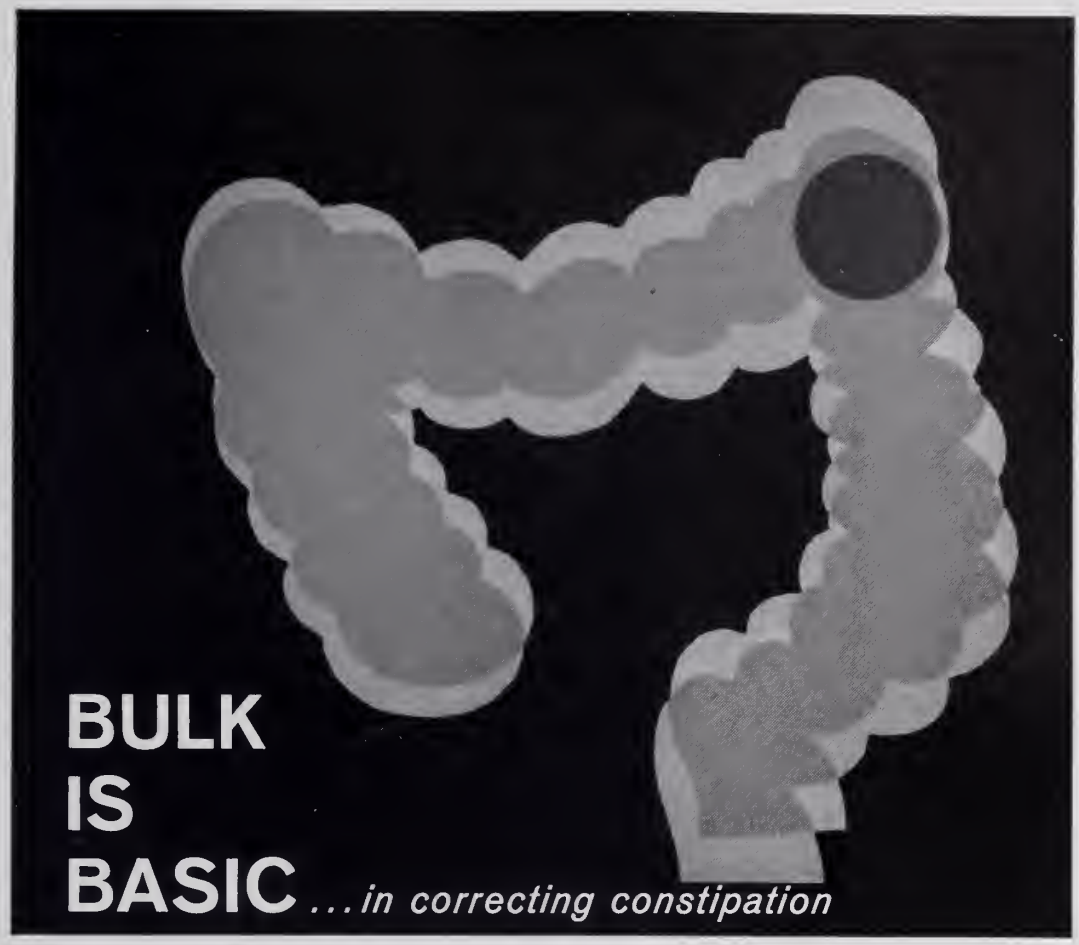
Gratefully yours,
John Porter Walton, M.D.

Doctor Cox Urges County Societies To Send Election Reports

David M. Cox, M.D., Louisville, president of the Kentucky State Medical Association, noting the importance of the coming year to the field of medicine, urges each county society to hold its election of officers and submit the names of these new officers to KSMA Headquarters as soon as possible.

Doctor Cox notes that in view of the importance of 1963 to medicine, KSMA should be at its full organizational strength as soon as possible after the beginning of the new year. It is important, says Doctor Cox, that all county society officers and committee personnel be invited to the 1963 KSMA Interim Meeting at Covington March 7 and early election of officers will enable these new officers to receive their invitations and make plans to attend this important session.

Forms on which county society secretaries should make their reports to KSMA Headquarters have been mailed to county society secretaries of record for the year 1962. They should be returned to KSMA Headquarters, 3532 Janet Ave., Louisville 5, Ky., as soon as possible.



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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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CHICAGO 80, ILLINOIS

Research in the Service of Medicine

Virgil Gillispie, M.D., Honored For 50 Years of Service

Virgil C. Gillispie, M.D., who started the practice of medicine at Wilmore, Ky., March 12, 1962, was guest of honor at an appreciation dinner honoring his half century of practice, given by the Wilmore Lions Club late in October. (See picture on page 0000.)

Wilmore Mayor Hugh B. Sims and a group of Kentucky physicians paid honor to Doctor Gillispie. Physicians who spoke included: Charles McChord, M.D.; Carl H. Fortune, M.D.; Thomas J. Overstreet, M.D., Francis M. Massie, M.D—all of Lexington, and Sam A. Overstreet, M.D., Louisville.

Dale E. Dunkelberger, M.D., Wilmore, presented a silver service to Doctor Gillispie from the Lions Club on behalf of the community.

Doctor Gillispie, who was born November 7, 1888, was graduated from the Medical Department of the University of Louisville in 1910. He estimates that he has delivered more than 6,500 babies during his more than 50 years of practice.

Doctor Simpson Reelected

G. L. Simpson, M.D., Greenville, immediate past president of the Kentucky State Medical Association, was reelected to his third term as chairman of the Governor's Advisory Committee on Indigent Medical Care November 21. Reelected also were: Vice chairman, E. M. Josey, Frankfort, secretary, Kentucky Pharmaceutical Association, and secretary, Miss Virginia Craft, Whitesburg.

First KAGP Fall Assembly Meets At Lexington November 8-9

The first Fall Scientific Assembly of the Kentucky Chapter of the American Academy of General Practice was held at Lexington, November 8-10. A total of 420 registered for the session, of whom 273 were physicians.

Scientific speakers at the first day's session included: Nicholas Pisacano, M.D., Lexington; W. H. Missildine, M.D., Columbus, Ohio; Ralph M. Denham, M.D., Louisville; J. Harold Kotte, M.D., Cincinnati; Buford Word, M.D., Birmingham, Ala.; Roderick Macdonald, Jr., M.D., Louisville.

The second day's session was addressed by: G. E. Burch, M.D., New Orleans; Daniel V. Jones, M.D., Cincinnati; James B. Donaldson, M.D. Philadelphia; Granger Westberg, D.D., Chicago; Doctor Word; H. William Clatworthy, M.D., Columbus. Doctors Clatworthy, Donaldson and Jones and Edmund D. Pellegrino, M.D., Lexington, addressed the session, November 10.

KAGP Seminar Slated January 24

The Northern Kentucky Seminar sponsored by the Kentucky Academy of General Practice will be held at the Sheraton Gibson Hotel, Cincinnati, Ohio, January 24.

V. O. Foster Passes Away

V. O. Foster, formerly secretary-treasurer of the Southern Medical Association and former executive secretary of the Tennessee State Medical Association, died last month of a heart attack.



Some of those who gathered at an appreciation dinner given by the Wilmore, Ky., Lions Club for Virgil C. Gillispie, M.D., who has practiced medicine at Wilmore for 50 years, are pictured here. Seated, left to right, Charles McChord, M.D., Lexington, and Doctor Gillispie. Standing, left to right, Dale E. Dunkelberger, M.D., Wilmore; Carl H. Fortune, M.D., Lexington; Sam A. Overstreet, M.D., Louisville; Francis M. Massie, M.D., Lexington, and Thomas J. Overstreet, M.D., Lexington. (See story on this page.)

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Submit Dates for P G Calendar

At this time of the year and in the next few weeks, many medical organizations are setting dates for their spring and summer meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Postgraduate Medical Education office of the Kentucky State Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Coming Education Opportunities" calendar in The Journal. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KSMA Postgraduate Medical Education Office, 3532 Janet Avenue, Louisville 5, Ky.

In Kentucky

DECEMBER

12-19	"Electrocardiogram Interpretation," 7 to 9 p.m., Wednesday evenings, Louisville General Hospital, Louisville, Ky.
13	Fifth Annual Postgraduate Medical Seminar, Norton Memorial Infirmary, Louisville, Ky.
20	Monthly University Surgical Day, University of Kentucky Medical Center, Lexington, Ky.
21	Postgraduate Grand Rounds, Department of Community Medicine, University of Kentucky Medical Center, 4-6 p.m., Lexington, Ky.
28	Pediatrics Department monthly program, 12:30 p.m., University of Kentucky Medical Center, Lexington, Ky.

JANUARY

2-9-16	"Electrocardiogram Interpretation," 7 to 9 p.m., Wednesday evenings, Louisville General Hospital, Louisville, Ky.
11	Kentucky Radiological Society, Sheraton Hotel, Louisville, Ky.
17	Monthly University Surgical Day, University of Kentucky Medical Center, Lexington, Ky.
24	KAGP Northern Kentucky Seminar, Sheraton Gibson Hotel, Cincinnati, Ohio.
24-26	"Cardiology," University of Kentucky Medical Center, Lexington, Ky.
25	Pediatrics Department monthly program, 12:30 p.m., University of Kentucky Medical Center, Lexington, Ky.

U. of K. Plans Cardiology Course

The University of Kentucky Medical Center is planning a course in "Cardiology" to be held January 24-26, 1963, covering two full days on Thursday and Friday, and a one-half day session on Saturday.

Guest speaker on Thursday will be Morris M. Weiss, Sr., M.D., Louisville, and on Friday, Sam Kaplan, M.D., Cincinnati.

The course is designed primarily for internists interested in cardiology and for cardiologists, but all physicians are welcome. Registration fee is $15 and includes two luncheons. Preregistration is requested since the course will not be given unless 12 enroll.

Additional information may be obtained from: Nicholas J. Pisacano, M.D., director, Continuation Medical Education, U. of K. Medical Center, Lexington.

FEBRUARY

8	Kentucky Radiological Society, Sheraton Hotel, Louisville, Ky.
21	Monthly University Surgical Day, University of Kentucky Medical Center, Lexington, Ky.
22	Pediatrics Department monthly program, 12:30 p.m., University of Kentucky Medical Center, Lexington, Ky.

Surrounding States

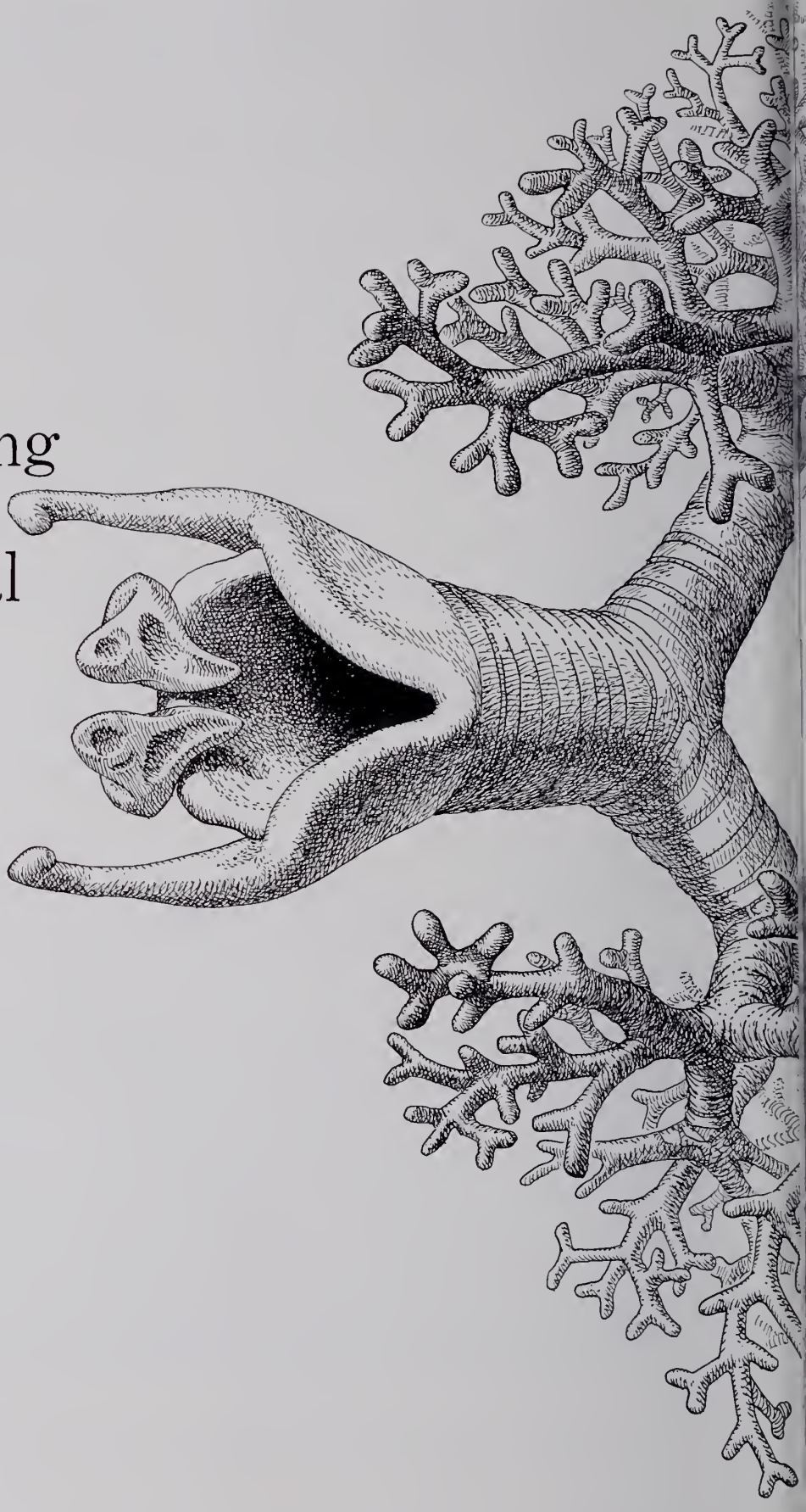
JANUARY

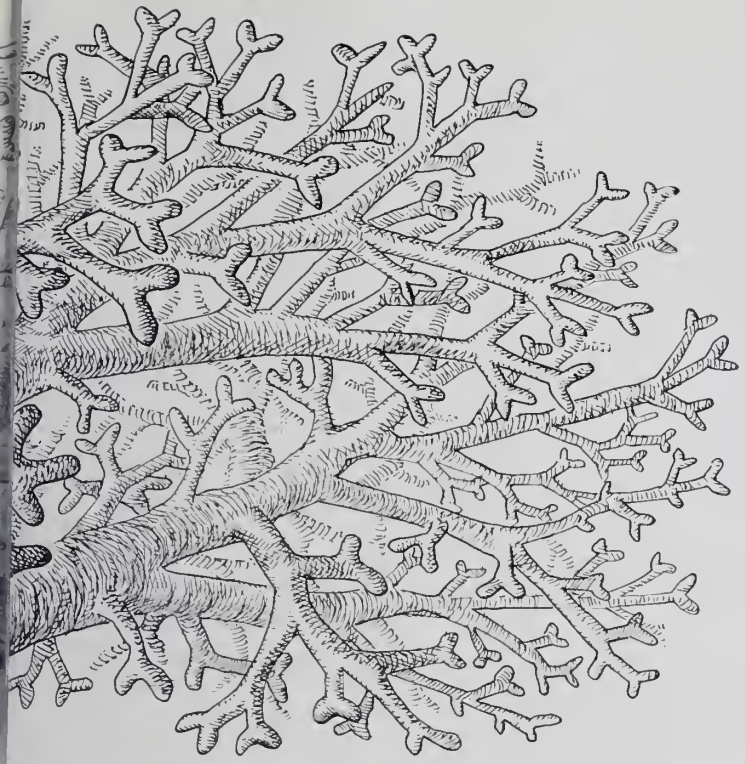
9-10	"Advances in Internal Medicine," Indiana University Medical Center, Indianapolis, Ind.
28-Feb. 1	Clinical III Diagnostic Use of Radio Isotopes, Oak Ridge Institute of Nuclear Studies, Medical Division, Oak Ridge, Tenn.

FEBRUARY

6-8	American Academy of Occupational Medicine, Sheraton Lincoln Hotel, Indianapolis, Ind.
6-9	American College of Radiology, Drake Hotel, Chicago, Ill.
10	Seminar on Gastroenterology, University of Cincinnati College of Medicine, Cincinnati, Ohio.
13	"Recent Developments in Diabetes Mellitus," Marion County General Hospital, Indianapolis, Ind.
21	"Ophthalmology for the General Practitioner," Indiana University Medical Center, Indianapolis, Ind.

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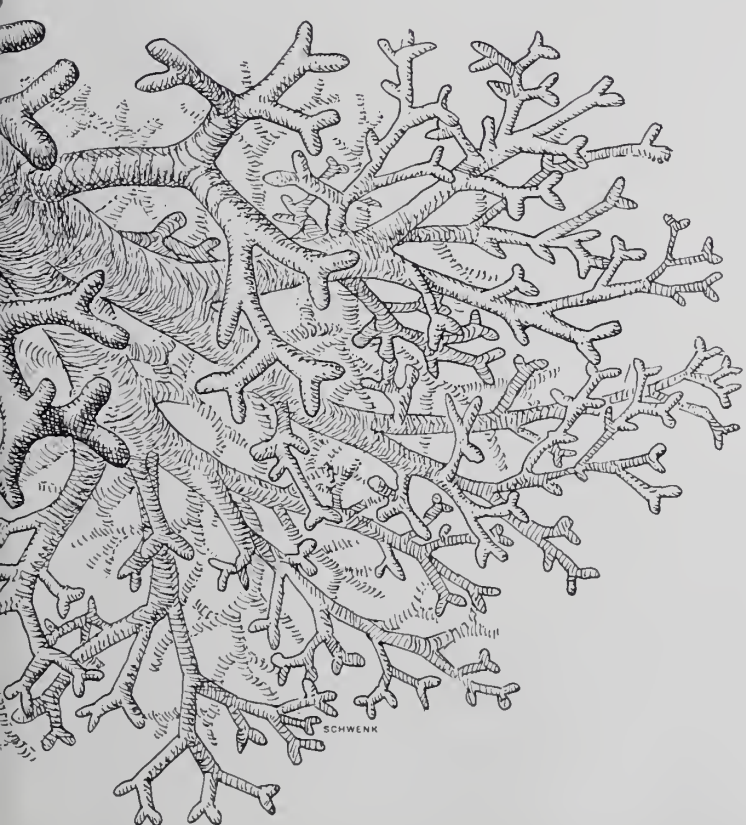




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Full List of New KSMA Members Is Given

The following is the list of new members of the Kentucky State Medical Association who joined the KSMA between September 1961 and September 1962:

Barren

Harris, O. W.

Bell

McCurry, Arthur

Boone

Waller, William M.

Bourbon

Farrell, J. L.

Boyd

Evans, E. G.
Nido, Michael P.
Sanders, Ted J.
Shaffer, S. A.
Webb, Charles A.
Wheeler, Joe S.

Boyle

Campbell, Logan
Darnell, K. B. Jr.

Campbell-Kenton

Couch, A.
Donovan, George
Egan, Thomas E.
Fragge, Ronald G.
Hemmer, R. E.
Moser, R. J.
Smith, Robert E.

Christian

Conran, Harold W.
Robertson, Jere Calvin

Daviess

Baumgarten, James A.
Deddens, Lloyd E.
Hast, Robert L.

Fayette

Edger, Donald E.
Eiseman, Ben
Gill, Charles R.
Githens, John H.
Greenlaw, R. H.
Hadley, Stanley Jr.
Hammond, Wylda
Hathoway, Wm. E.
Hodges, Samuel O.
Lieber, Arthur
McElvein, R. B.
Mulling, Rudolph Jr.
Nelson, Thomas L.
O'Gorman, R. W.
Reeves, John T.
Spencer, Frank C.
Tufts, Kenneth C.

Floyd

Adams, James D.
Patterson, J. L.

Franklin

Baker, Thomas H.
Hagg, Dallas C.
Johnson, William A.
Lauder, M. Stuart

Fulton

Nelson, Andrew P.

Gallatin

Esteves, J. E.

Grant

Shipp, D. B.

Graves

Van Arsdall, J. R.
Reed, John M.

Harlan

Bahn, Richard A.
Gross, Frank B.
McCormick, Harry M.
Salter, John J.
Summer, Alvan J.

Hopkins

Ainsworth, Geo E.
Bettasso, Robert
Edwards, I. K.
Sigdo, Frederick

Jefferson

Allen, Stiles W.
Altman, Ivan
Barton, A. Glenn
Blankenship, Chas. A.
Bradley, Herbert C.
Carnes, Edwin
Collins, David M.
Cox, Warren M.
Dickinson, Grady Lee
Grumbles, Cecil L.
Hacker, Elmer B.
Haick, Edward
Hale, Joan
Howell, Joyce E.
Hughes, Walter T.
Koch, Edwin F.
Koby, Jay S.
Landau, Gerald
Leneave, Charles D.
McGallon, Dorothy
McPherson, Richard C.
Marshall, Thomas R.
Marshall, Wm. H.
Moore, Harry G. Jr.
Overstreet, A. Evan
Owens, Jack W.
Richman, Anne D.
Richmond, Ronald W.
Ryan, John F. Jr.
Sergeant, Charles K.
Smith, Charles
Stodghill, William
Sutherland, James P.
Urton, John
White, George W.
Weiss, Morris Jr.
Wing, Herman
Wolfson, Norman

Jessamine

Combs, Wallace

Lee

Noble, Carl

Letcher

Nash, Arthur J.
Tolliver, Jim B.

Mathis, Charles H.	Logan
Wood, Dewey E.	McCracken
Berman, M. M.	Madison
Kerby, Clifford F.	Marshall
Gordon, W. E.	Mason
Franz, Lyle C.	Nicholas
Pendergrass, W. R.	Owen
Schiavone, Robert	Perry
Leonard, J. J.	Pulaski
Penn, T. J.	Rockcastle
Lewis, Jack D.	Trimble
Cooper, John I.	Whitley
Barton, D. C.	

Doctor Limper Joins KCCC

Margaret A. Limper, M.D., Louisville pediatrician, has closed her private office and joined the Kentucky Commission for Crippled Children as pediatric consultant. She is the Commission's first full-time consultant. Doctor Limper is a 1929 graduate of the University of Louisville School of Medicine and studied also at the Indiana University Medical School. She is associate professor of pediatrics at the U. of L.

SMA Honors C. P. Loranz

C. P. Loranz, advisor and special consultant to the Southern Medical Association, was honored October 7 on the completion of 50 years of service to the SMA. A special luncheon was held in his honor at the Mountain Brook Country Club, Birmingham, Ala., and a bronze plaque presented to him.

35 Attend Thoracic Society Meet

A total of 35 physicians attended the meeting of the Kentucky Thoracic Society November 15 at Jenny Wiley State Park. Speakers included: Richard E. Mardis, M.D., Louisville; Paul Fauth, Louisville; S. A. Shaffer, M.D., Ashland; Herbert Ransdell, Jr., M.D., Louisville. Nathan Levene, M.D., Louisville, read the paper of E. R. Gernert, M.D., Louisville, when the latter was unable to be present.

The Department of Otolaryngology of the University of Illinois College of Medicine will conduct a postgraduate course in "Laryngology and Bronchoesophagology," March 18-30, 1963, under the direction of Paul H. Holinger, M.D. Registration will be limited to 15 physicians. For more information write the Department at the College, 1853 West Polk Street, Chicago 12, Ill.

The 27th annual session of the International Medical Assembly of Southwest Texas will be held January 28-30, 1963, at the Granada Hotel, San Antonio.

Doctor Van Meter Heads Council

J. Farra Van Meter, M.D., Lexington, was named president of the Kentucky Council of Churches November 6 at the close of the Council's two-day assembly and pastors' conference at Lexington.



Doctor Van Meter

Doctor Van Meter, prominent in medical association circles as well as in church and community activities, is a former chairman of the Council, forerunner to the present board of trustees of the Kentucky State Medical Association. He is also a former chairman of the Kentucky Chapter of the American Cancer Society.

Ky. Health Department Reorganized

The Kentucky State Health Department has been reorganized from six bureaus and 34 divisions into six administrative divisions. Governor Bert Combs called the move, made at a meeting of Health Department employees, one to "increase the efficiency of administration."

Russell E. Teague, M.D., commissioner of health, said the reorganization will help to reduce administrative costs. New divisions and their directors are: Medical services, William H. McBeath, M.D.; maternal and child health, Helen B. Fraser, M.D.; public health laboratories, Buster F. Brown, M.D.; environmental health, Ralph C. Pickard; research, planning and statistics, Strawn W. Taylor; administrative services, William A. Kanzinger. Local health affairs will be coordinated from the Commissioner's office by Edward L. Thompson, M.D.

Doctor Baker, Grayson, Honored

Boyd Van Buren Baker, M.D., general practitioner at Grayson, Ky., was one of 33 physicians and two dentists honored at special exercises by the University of Tennessee Medical Units. Doctor Baker was cited for his 50-year service in the field of medicine. He was graduated in 1912 from the Medical Department of Lincoln Memorial University which was consolidated with U. of T. in 1914.

Thomas Kirby, M.D., has entered the practice of internal medicine in association with the Graves-Gilbert Clinic at Bowling Green, Ky. Doctor Kirby received his M.D. degree from the School of Medicine of the University of Louisville in 1954. He interned at San Diego, Calif., County General Hospital and had his residency training at the Cleveland Clinic and the Crile Veterans Administration Hospital. Doctor Kirby was previously in general practice at Central City, Ky., until 1959.

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In Memoriam

W. L. OZMENT
Leitchfield
1876-1962

W. L. Ozment, M.D., 86, Leitchfield, general practitioner for more than 50 years, died October 29 at Kentucky Baptist Hospital, Louisville. He had been a patient at the hospital for two weeks.

Doctor Ozment was graduated from the Medical Department of the University of Louisville in 1913. He practiced at Short Creek and Caneyville before moving to Leitchfield. Although in declining health in recent years, he had continued to practice until shortly before his death.

HARLAND V. USHER, M.D.
Mayfield
1880-1962

Harland V. Usher, M.D., 82, Mayfield, who had practiced medicine in western Kentucky since 1905, died October 31 after a brief illness. He was in active practice until October 28 when he suffered a stroke. Doctor Usher was graduated from the University of Louisville School of Medicine in 1905. He was Graves County health officer for seven years and had practiced at Mayfield since 1945. Before that he was in practice at Kirksey, Oscar and Sedalia.

LOUISE BERGMAN HEALY, M.D.
Lexington
1868-1962

Louise Bergman Healy, M.D., 94, Lexington, died October 23. She was a graduate of Woman's Medical College of Pennsylvania at Philadelphia and was on the staff of Eastern State Hospital, Lexington, for many years.

WILLIAM F. BOYER, M.D.
Louisville
1921-1962

William F. Boyer, M.D., 41, a 1951 graduate of the University of Louisville School of Medicine, died October 5 at Veterans Hospital, Louisville, of a brain tumor. Doctor Boyer had been in general practice at Louisville for the past five years.

PAUL S. OSBORNE, M.D.
Louisville
1898-1962

Paul S. Osborne, M.D., 64, Louisville, died November 6 at his home. Doctor Osborne, who once served as Jefferson County Coroner, had been a physician in Louisville since 1926. He was graduated from the Medical Department of the University of Louisville in 1925.

STANLEY GIBSON ODOM
Ft. Mitchell
1887-1962

Stanley Gibson Odom, M.D., 74, Ft. Mitchell, retired Army physician and EEN&T specialist, died October 3 at his home. Doctor Odom retired in 1949 after 31 years in the U. S. Army Medical Corps and took over the practice of R. W. Bledsoe, M.D., in Covington in that year. He retired from active practice in July 1961 because of illness.

Doctor Odom was graduated from Birmingham Medical College, now part of the University of Alabama, in 1913.

ORION WENDELL HARRIS
Madisonville
1908-1962

Orion Wendell Harris, M.D., 54, Madisonville, died October 23 in his apartment at Kentucky State Tuberculosis Hospital. Doctor Harris had been transferred to Madisonville in October from Glasgow, to which he had been transferred from Madisonville about a year ago. He was a graduate of Vanderbilt University Medical School in the class of 1933.

J. W. YORK, M.D.
Phoenix, Arizona
1884-1962

J. W. York, M.D., 78, Phoenix, Ariz., who had practiced in south central Kentucky for 45 years, died November 14 at a Phoenix nursing home. Doctor York was a graduate of the University of Tennessee Medical School and practiced first in Barren County for three years and then for 42 years at Canmer, Ky. He retired about five years ago and moved to Phoenix.

ROBERT BURKE SUITT, M.D.
Harlan
1907-1962

Robert Burke Suitt, M.D., 55, Harlan, chief of psychiatric services, Harlan Memorial Hospital, died October 20 in that hospital after an illness of several months. Doctor Suitt was a graduate of the St. Louis School of Medicine and had served on the faculty of Duke University School of Medicine.

County Society Reports

McCracken County

H. Goodloe Sargent, M.D., Barlow, Ky., was the guest speaker at the September 12 meeting of the McCracken County Medical Society. Doctor Sargent discussed D.N.A. (Desoxy Nucleic Acid) and R.N.A. (Ribose N-A) as related to cell growth, reproduction, viral immunization and possible control, of malignancy.

H. Rex Holland, M.D., Paducah, chairman of the polio program, commented on its progress bringing the members up to date on places for mass administration of Sabin vaccine, October 7, November 11 and December 16.

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PUBLIC HEALTH PAGE

Incidence of Drug Resistance of Tubercle Bacilli*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE emergence of drug-resistant bacterial strains has been a serious problem ever since antibiotic treatment was started. This is just as true of the tubercle bacillus as it is of the staphylococcus, and the danger is recognized as an important factor in the planning of a program of treatment for the individual case of tuberculosis. Even so, a proportion of tuberculous patients do develop a significant degree of drug resistance under treatment. While this is primarily a therapeutic problem, there is potentially an equally serious public health problem.

Discharge Records Examined

In 1960-61, 24.7% of patients leaving the State Tuberculosis Hospitals received irregular discharges. A review of discharge records since October 1961 shows that, of all the patients for whom we have this information, only 25% of patients receiving regular discharges showed bacterial resistance compared to 70% of irregular discharges.

In short, we know that there are, and have been, a number of inadequately treated cases of tuberculosis spreading drug-resistant bacilli. It is very important that we should know how serious a problem they represent. In order to evaluate this, we need to know what proportion of new cases, previously untreated, have been infected with resistant bacilli.

The U.S.P.H.S. has made a grant to the Division of Tuberculosis Control for a study of this subject in cooperation with the State Public Health Laboratories.

Starting almost at once, every positive sputum culture for tubercle bacilli isolated by the State Public Health Laboratory will be tested routinely for resistance to streptomycin, isoniazid and P.A.S.; and the result will be reported to the submitting physician.

The immediate detection of drug resistance, if it is present, will be of great value to the physician and the patient as it will ensure that antibacterial therapy is effective.

From the public health point of view, this study will provide a great deal of valuable information about the magnitude and nature of the problem as it is now, and it will give a basis on which to evaluate the problem in the future.

History of Previous Treatment

For this purpose, we need to know something about each individual patient who has a positive culture, particularly with regard to his history of previous treatment for tuberculosis.

In order to obtain the necessary information about the patient for the study, a short, simple questionnaire will be enclosed with the positive culture report.

We would be most grateful if you would fill out and return this questionnaire promptly, as the value of the study depends on the completeness of the information available.

**This article was prepared by M. Stuart Lauder, M.D., C.M., director, Tuberculosis Control, Kentucky State Department of Health, Frankfort, Ky.*

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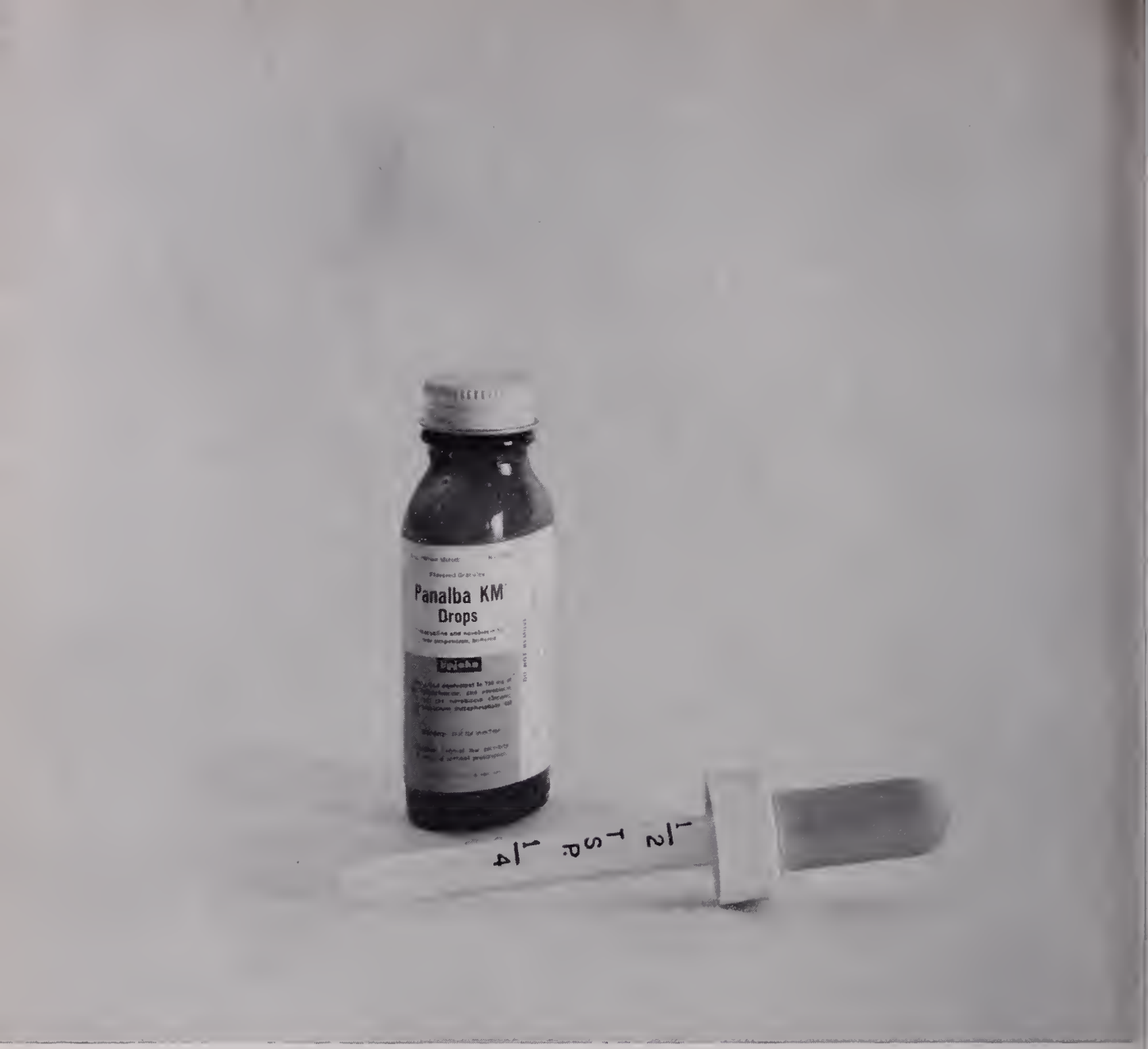
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IN THE BOOKS

SURGERY OF THE CHEST: edited by John H. Gibbon, Jr., M.D.; published by W. B. Saunders Co., Philadelphia; 902 pages; price, $27.

Doctor Gibbon has accomplished a monumental feat in this volume. He has accumulated, in one well-written text, the present-day knowledge of aspects of diseases of the chest amenable to surgical correction.

Each disease is well covered as to pathology and etiology, diagnosis, indications for surgery, pre- and postoperative care, operative techniques, complications and prognosis.

Thirty-three chapters by 35 authorities in their respective fields from the United States, Canada and England, completely cover the field of surgery of the chest. Included are 11 chapters on cardiorespiratory dynamics, endoscopy, preoperative evaluation and preparation, and postoperative management of the chest patient. There are 11 chapters devoted to the chest wall, pleura, lungs, mediastinum, and diaphragm and 11 chapters, to the aorta, pericardium and heart, including chapters on hypothermia, open cardiotemy, cardiac pacemakers and prosthetic heart valves.

Each chapter is profusely illustrated, and the bibliography of each is thorough and up-to-date. Surgical techniques are well described and beautifully illustrated.

Doctor Churchill, in his foreword of this book, states, "This 'Surgery of the Chest' reduces its predecessors to works of only historical importance." I heartily agree with Doctor Churchill. I believe that a physician doing any type of general or chest surgery, and particularly every chest surgeon, should have this book in his library for ready reference.

Herbert Ransdell, Jr., M.D.

FUNDAMENTAL SKILLS IN SURGERY: by Thomas F. Nealon, Jr., M.D.; published by W. B. Saunders Co., Philadelphia; 289 pages; price, $8.50.

This is the first edition of an interesting new type of surgical textbook. The author has directed his approach in an area that many past works have attempted in part but to which they have never devoted their entire pages.

This book is intended primarily for medical students, interns and young residents. It goes into details of the armamentarium of the young doctor in regard to instruments, proper operating room conduct, sutures, surgical dressings, anesthesia, and the care of various diseases. These are all approached in a very elementary way with full description so that even the simplest task, such as tying a surgical knot, is well understood.

The book is amply filled with diagrams and pictures which accompany the written word. A bonus found in the book are pieces of worthy advice of simple measures that can be used under rather trying situations, and can be applied even by the novice.

This is a basic book, and can be well utilized by any of the above mentioned neophytes. It attempts to answer completely the simple, ordinary, everyday questions that frequently need to be answered, but too commonly are not asked by the young physician because he fears everyone else knows the answers but himself.

Considerable care has been devoted in programing of the text. It is broken down into short paragraphs, and each area of change is documented in bold, large print so that the book is well-organized and any specific item desired can be found with a minimum amount of searching.

The material in this work can be well recommended to the student, intern and young resident for a help in learning the basic skills. It can also be recommended to the practicing physician who wishes a review. Finally, it can be recommended to the well-read physician because it is well done and can be comfortably read and enjoyed.

Hoyt D. Gardner, M.D.

TEXTBOOK OF PATHOLOGY WITH CLINICAL APPLICATION: by Stanley L. Robbins, M.D.; published by W. B. Saunders Co., Philadelphia; 1190 pages; price: $19.

In the preface, the author states his goal to be "the presentation of the subject matter in a logical, concise, readable fashion." The book is logical and readable. Conciseness is a relative thing. This volume weighs 3,570 grams (almost eight pounds), an increase of 120 grams over the weight of the previous edition. Some of this weight represents a heavier cover, designed to survive longer in the stress of a medical school environment.

This volume is intended for medical students and clinicians. To this end, much space is devoted to clinical symptomology and clinical-pathological correlations. Many of these sections are quite valuable in stimulating student interest. Some appear unnecessarily long and detailed, such as "the life history of a malignant tumor," which represents a four-page case history.

Two sections have changed authors. The chapter on "Inflammation and Repair," although under new authorship by Sir Roy Cameron, has not been changed appreciably from the first edition. The section on Adrenal, rewritten by Professor Tom Symington, has been extensively revised and improved.

No volume is perfect and this one is not without its faults. This edition, like the first, persists in implying that epithelioid cells are specific for tuberculosis. Some students using this text can be expected to re-

produce this error on an examination. Fortunately, flaws of this sort are few and far between.

Taken as a whole, this is a very good basic text. Its chief merits appear to be readability, logical format and bibliography. References are limited in number, selected with care, and a brief description of the contents of each reference is included.

James T. Packer, M.D.

Ewen L. Fraser, M.D., has been appointed acting superintendent of Outwood Hospital and Training School at Dawson Springs. Patient population at Outwood will eventually number about 500. He has formerly been at Central State Hospital, Kentucky State Hospital and Eastern State Hospital.

Edward N. Mogan, M.D., has joined the Trover Clinic, Madisonville. He will limit his practice to pediatrics. Doctor Mogan was graduated from the University of Tennessee Medical School in 1956 and interned at Roanoke Memorial Hospital, Roanoke, Va. He did his residency training at the University of Tennessee and at St. Joseph Hospital, Memphis. Previously he was with the health department and in general practice at Nashville, Tenn., and practiced pediatrics at Memphis.

Edward J. Fadell, M.D., and **Anne D. Richman, M.D.**, Louisville, have opened an office in Louisville for clinical and diagnostic pathology. Nicholas J. Mamola, biochemist, is associated with the office. Doctor Fadell is a graduate of St. Louis University School of Medicine and Doctor Richman is a George Washington University Medical School graduate.

Alice Pickett, M.D., retired Louisville physician and professor emeritus of Obstetrics and Gynecology of the University of Louisville School of Medicine, was one of five women honored October 11 for their contributions to the community at a 50th Anniversary Celebration of Social Action by the Louisville Section of the National Council of Jewish Women and the Young Women's Christian Association.

Philip C. Brooks, M.D., Hopkinsville, was elected to the Hopkinsville Board of Education in the November 6 general election. Doctor Brooks was on the staff of Western State Hospital before beginning practice at Hopkinsville in 1930. He has operated the Brooks Memorial Hospital since 1944.

Crocker B. Clegg, M.D., Elizabethtown, Ky., surgeon, was elected Hardin County coroner in the November 6 general election. Doctor Clegg was graduated from the University of Louisville School of Medicine in 1950.

James S. Brashear, M.D., has begun the general practice of medicine at Central City, Ky., in association with **R. E. Davis, M.D.** Doctor Brashear was graduated from the University of Louisville School of Medicine in 1961. He interned at St. Joseph Infirmary, Louisville.

William J. Graul, Jr., M.D., has begun general practice at Versailles, Ky. Doctor Graul received his M.D. degree from the University of Louisville in 1961 and interned at the University of Texas, John Sealy Hospital, Galveston.

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*Asherson, N., "Acute Otitis and Mastoiditis in General Practice," H. K. Lewis & Co., Ltd., London, 1934.

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1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



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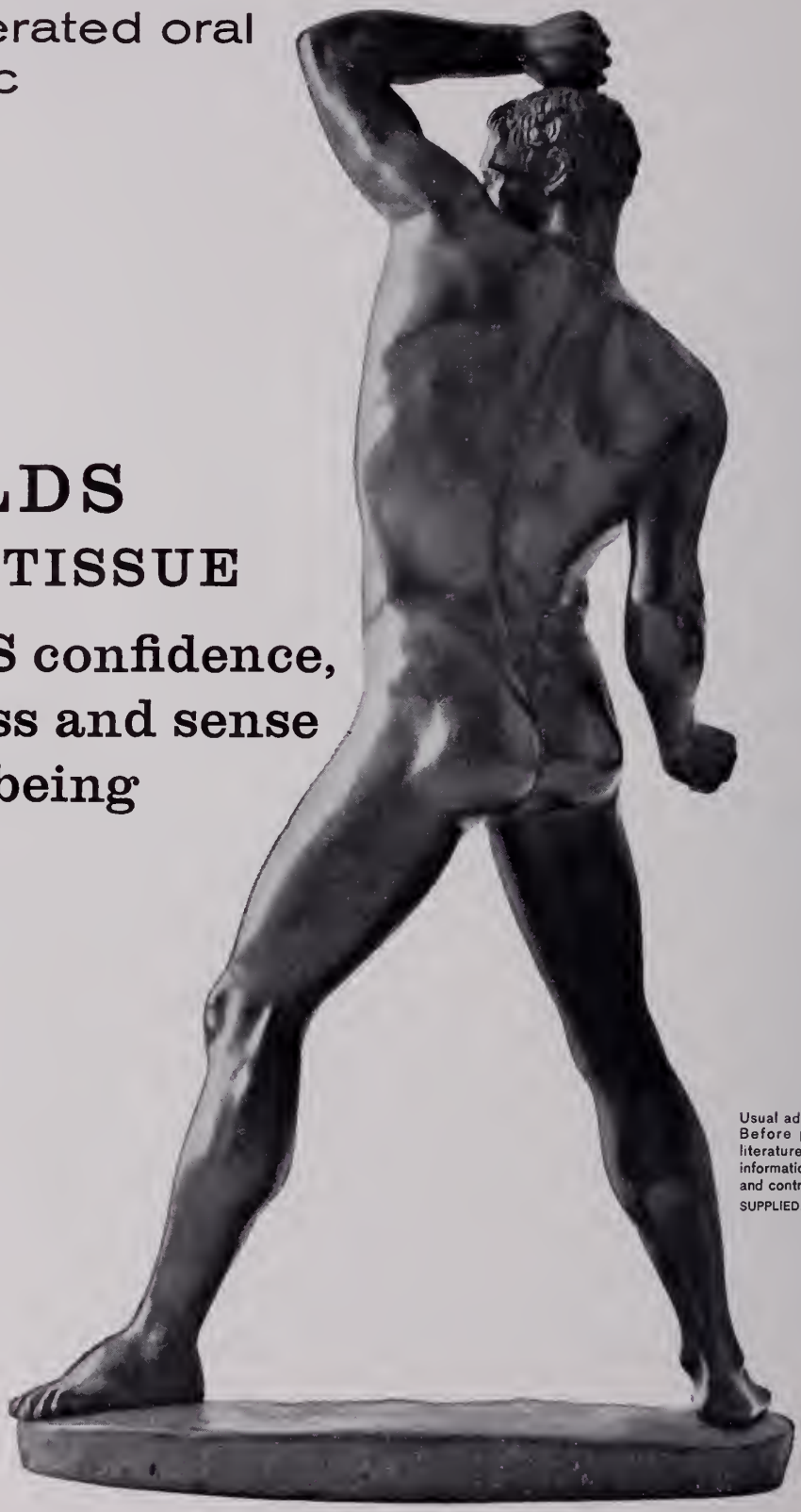
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1962 CONSTITUTION AND BYLAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Revised September 19, 1962

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker contrary to or at variance with any policy established by the House of Delegates.
of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active

membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Standing Committees and Councils
Chapter VIII. Assessments and Expenditures
Chapter IX. Rules of Conduct
Chapter X. Rules of Order
Chapter XI. County Societies
Chapter XII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KSMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded

the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active members of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 5, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a

non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. Collectively the Board shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a component society upon which appeal is taken from the decision of an individual Trustee or District Grievance Committee. In hearing appeals, the Board may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts toward conciliation and compromise shall precede all such hearings. Its decision in all such cases shall be final.

Section 5. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 6. The Journal of the Kentucky State Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 7. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 8. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 9. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition,

the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 10. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky State Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of five standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws
(b) A Committee on Third-Party Medicine
(c) A Committee on Professional Relations
(d) A Committee on Arrangements for the Interim Meeting.
(e) An Advisory Committee to the Editor of the Journal

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all Committees and Councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recommendations will be considered by the Board of Trustees unless and until reviewed by the proper council.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the

Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Professional Relations Committee shall supervise and coordinate the work of the various District Grievance Committees hereinafter created. The Trustee of each District is hereby designated the Chairman of his District Grievance Committee. The Professional Relations Committee shall designate two (2) additional Trustees from Districts adjoining that of the Chairman, and the three Trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual Trustees, shall be referred to the District Grievance Committee for the District in which the respondent physician or county society resides. If requested to do so, the District Grievance Committee shall hold hearings and hear evidence and render a decision based upon the evidence thus presented. Any party aggrieved by the decision of the District Grievance Committee, shall have the right to appeal to the Board of Trustees in the manner provided by Section 4 of Chapter VI of these Bylaws.

All grievances, whether handled by individual Trustees or by District Grievance Committees, shall be reported to the Professional Relations Committee, which shall include in its report to the Board of Trustees, a statistical resume of the number of cases handled and the disposition thereof. In addition, the Professional Relations Committee shall make recommendations to the Board of Trustees with respect to any course of action which the Committee determines to be desirable, in the light of its experience during the year covered by its report.

Section 10. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 11. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 12. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 13. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Education Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 14. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 15. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 16. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 17. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER VIII. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $50, except Active Members who devote all of their time to teaching or research and have no private practice, $25; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates,

and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER IX. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER X. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XI. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky State Medical Association, and shall be classified in accordance with Chapter I, Section 2, of these Bylaws. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides. (Disciplinary procedures are governed by Section 4, Chapter VI of these Bylaws.)

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Board of Trustees, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Board of Trustees to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Board of Trustees.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day

of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KSMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky State Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.

The Cleveland, Ohio, Clinic Educational Foundation is sponsoring a postgraduate continuation course in "Surgery of the Head and Neck" to be presented January 9-10, 1963. Further information may be obtained from the Foundation (formerly the Frank E. Bunts Educational Institute), 2020 East 93rd Street, Cleveland 6, Ohio.

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1. Ford, R. A., and Blanchard, K.: Journal Lancet 78:185, 1958.

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1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.

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3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

Study involving 620 patients, 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

[Bonadoxin] "was found clinically effective in the prevention of pre-operative and post-operative nausea and emesis in 157 patients who underwent ocular surgery, while control drugs alone could not completely eliminate the symptoms. Bonadoxin did not cause side reactions in the preoperative or postoperative phase of this study."[5]

6. Bethea, R.C.: International Record of Med. (May) 1960.

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

7. Sklaroff, D.M.; Karayannis, N.: Current Therapeutic Research (June) 1962.

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